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ABSTRACT

This Kids Count report examines trends in the well being of Tennessee's children. The statistical portrait is based on 23 indicators of child well being: (1) single-parent families; (2) family income/poverty; (3) children receiving Aid to Families with Dependent Children; (4) students participating in school nutrition programs; (5) teen unemployment rate; (6) child abuse and neglect rate; (7) children referred to juvenile courts; (8) child commitment rate to state care/custody; (9) enrollment in state health insurance program; (10) prenatal care rate; (11) low-birthweight rate; (12) infant mortality rate; (13) immunization rate; (14) child death rate; (15) teen pregnancy rate; (16) teen drug abuse; (17) teen HIV/AIDS incidence; (18) teen sexually transmitted disease rate; (19) teen violent death rate; (20) academic achievement; (21) students receiving special education; (22) high school dropout rate; and (23) incidence of school violence. Following an executive summary, the data are presented in three sections. Section 1 indicates that more than 25 percent of Tennessee children live in poverty and juvenile court referrals for violent crime has more than doubled in the last decade. Section 2 reveals that nearly a third of 1992 births lacked adequate prenatal care, nonwhite infant mortality was more than twice the white rate, child mortality declined 28 percent from 1980 to 1992, and the rates of pregnancy and sexually transmitted diseases declined from 1991 to 1992. Section 3 indicates that the high school dropout rate declined 24 percent from 1991 to 1992 and firearm-related expulsions increased dramatically from 1990 to 1992. (KB)

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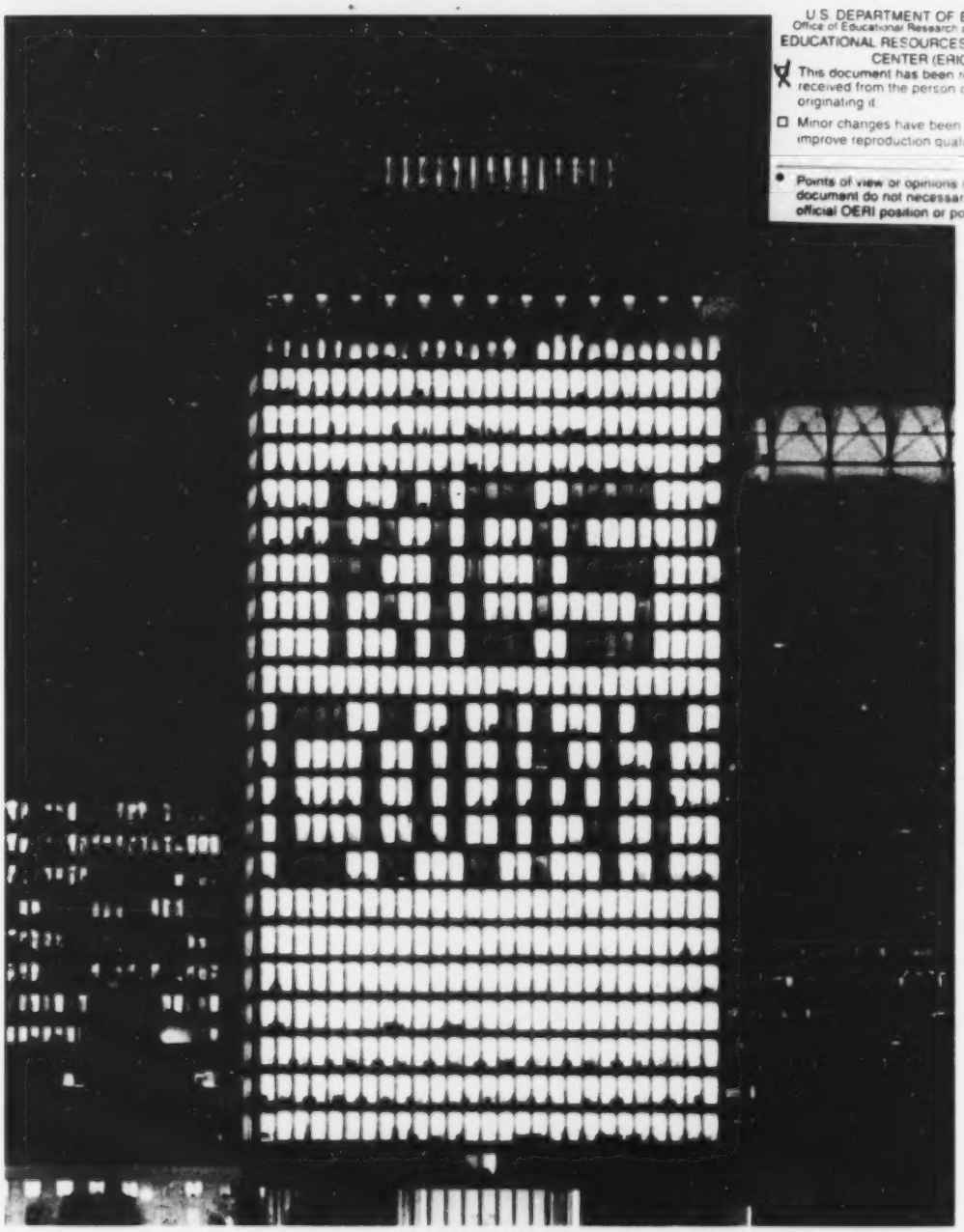
TENNESSEE kids count

Kids Count

The State of the Child in Tennessee 1994



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Tennessee KIDS COUNT
The State of the Child in Tennessee, 1994

TENNESSEE COMMISSION ON CHILDREN & YOUTH
TENNESSEE KIDS COUNT
GATEWAY PLAZA BUILDING, FIRST FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0800

(615) 741-2633
1-800-264-0904
FAX: (615) 741-5956

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The state of Tennessee is an equal opportunity, equal access, affirmative action employer.

This publication is dedicated to the memory of Jim Pryor.

Tennessee Commission on Children and Youth member Jim Pryor passed away May 17, 1994.

A May 19 proclamation by the Tennessee House of Representatives reflects the feelings of many. It says, in part: "...it was with great sorrow and a profound sense of loss that the members of this General Assembly learned of the untimely death of our friend, James F. Pryor... Jim Pryor was acknowledged and deeply respected as an energetic scholar and leading advocate on matters pertaining to the protection of children and the promotion of child health, safety, and well-being ... Jim tirelessly served the citizens of Tennessee with great industry and intelligence ..."

Mr. Pryor was a member of the Northeast Council on Children and Youth, a charter member and first chairman of the Tennessee Network for Child Advocacy, a member and chairman of the Tennessee Child Sexual Abuse Task Force, a founding member of the Tennessee Chapter of the American Professional Society on the Abuse of Children, and the founder of the Child Abuse Prevention Center of Northeast Tennessee.

An attorney and a graduate of the University of Tennessee College of Law, Mr. Pyror served as Faculty Staff Attorney at the Legal Clinic of the UT College of Law, as an Assistant District Attorney in Knox County, and as Chief Assistant District Attorney of the Third Judicial District.

He was a member of the First Baptist Church, Greeneville, where he taught Sunday school.

He is survived by his wife, M.E. Pryor, and two children, Laura Kimberlee Pryor and James Russell Pryor.

Jim Pryor was a man of considerable charm, humor and intelligence. He is deeply missed.

Table of Contents

Forward 4
Executive Summary 5

CHAPTER 1: FAMILY AND COMMUNITIES
Single-Parent Families..... 8
Poverty..... 10
AFDC..... 12
Nutrition..... 14
Teen Employment..... 18
Domestic Violence..... 20
Child Abuse..... 22
Teen Crime..... 24
State Care, Custody..... 28

CHAPTER 2: HEALTH
TennCare..... 34
Prenatal Care..... 36
Low Birth Weight..... 38
Infant Mortality..... 40
Immunizations..... 42
Child Deaths..... 44
Teen Pregnancy..... 46
Drug Abuse..... 50
HIV/AIDS..... 51
STDs..... 52
Violent Deaths..... 54

CHAPTER 3: EDUCATION
Enrollment, etc. 58
Student Learning..... 60
ACT Scores..... 62
Special Education..... 64
Dropping Out..... 66
School Violence..... 68
References..... 71
Glossary..... 75
Appendix 75
Acknowledgments..... 76

FORWARD

Kids Count: The State of the Child in Tennessee is the most comprehensive report on the health, education, social and economic indicators of well-being for children in the state. The Tennessee Kids Count Project is part of a national and state-by-state effort to track the status of children in the United States. By providing policy makers and citizens with benchmarks of child well-being, Kids Count seeks to enrich local, state, and national discussions concerning ways to secure better futures for all children.

The Tennessee Kids Count Project is administered by the Tennessee Commission on Children and Youth (TCCY), an independent state agency created by the Tennessee General Assembly. The primary mission of the commission is advocacy for improvements in the quality of life for Tennessee children and families. TCCY collects and disseminates information on children and families for the planning and coordinating of policies, programs and services, administers and distributes funding for teen pregnancy prevention programs, improvements in juvenile justice, and evaluates the implementation of Tennessee's Children's Plan.

There has been a Commission on Children and Youth or Children's Services Commission in Tennessee since the 1950s. The current statutory framework of the Commission on Children and Youth was enacted in 1988. The 21 commission members, appointed by the governor for three-year staggered terms, serve as the policy board for the agency. Each development district is represented by at least one commission member, and the commissioners of state departments serving children are ex-officio members. The commission also has youth advisory members as necessary to meet the requirements for serving as the State Advisory Group under the federal Juvenile Justice and Delinquency Prevention Act.

The commission staffs and coordinates nine regional councils that address local needs of children and families, provide organizational structure for statewide networking on behalf of children and families, and provide local input to the commission. Council members include children's services professionals and other citizens interested in improving the lives of Tennessee children.

The goal of the Tennessee Kids Count Project is to increase public awareness of the plight of many children and encourage grassroots support for public and private efforts to improve their quality of life.

Tennessee is one of 48 states to receive a four-year, $400,000 Kids Count grant. The grant program is funded by The Annie E. Casey Foundation, the nation's largest philanthropy devoted exclusively to disadvantaged children. Based in Baltimore, Maryland, the foundation was established by the founders of United Parcel Service to improve family and community environments that shape young people's health, development, education, opportunities and aspirations.

At the national level, the principal activity of the initiative is the publication of the annual *KIDS COUNT Data Book*, which uses the best available data to measure the educational, social, economic, and physical well-being of children. The Casey Foundation is funding the state-level KIDS COUNT projects to provide a more detailed, community-by-community picture of the condition of children.

Through the Kids Count Project, understandable information about the well-being of children is gathered and disseminated so citizens, advocates, policy makers, and political leaders will have timely and reliable information.

EXECUTIVE SUMMARY

The statistical information in this report was gathered from raw data and reports generated by other Tennessee state agencies or state departments, the U.S. Census Bureau, and other sources of data on children. The most current available data are presented here. Narratives on each child well-being indicator were developed to provide contextual information for the county-by-county statistics. An analysis of the data in this report reveals vital information on the quality of life for Tennessee's children. The major findings of this report are listed here.

CHAPTER I - FAMILIES AND COMMUNITIES

Single-Parent Families

Tennessee ranks second worse among the states in the percent of children living in single-parent families. From 1985 to 1991, there has been a 33 percent increase. Children from single-parent families are more likely than children living with two parents to live in poverty, have low academic achievement, and become involved with the juvenile justice system.

Poverty, AFDC, and Child Nutrition Programs

More than a fourth of Tennessee children live in poverty. Current AFDC payments in Tennessee are not enough to bring families out of poverty. The maximum AFDC benefit a family of three in Tennessee can receive is $185 per month while the national average benefit level is $393.

Many Tennessee students who are eligible to participate in the government-subsidized, free- and reduced-price breakfast program cannot do so because their schools do not offer it. Although the School Breakfast Program is an entitlement program, it is not available to 18.2 percent of the eligible children.

Teen Crime

The number of referrals to juvenile courts in Tennessee for violent crimes has more than doubled in the past decade. Many factors that are strong predictors of violent behavior are known. They include increased availability of firearms, alcohol and other drugs. Other important factors predictive of teen crime include lack of parental supervision, poverty and single parenthood. In 1992, only 13.7 percent of juveniles referred for murder in Tennessee lived with both parents.

Children in State Care or State Custody

Since Tennessee's Children's Plan was implemented in 1991, the number of new commitments has been fairly stable. Prior to The Children's Plan, new commitments to state care increased 65 percent between FY 1983-84 and FY 1990-91. Between FY 1990-91 and FY 1993-94 there was an eight percent increase in commitments. Approximately one percent of Tennessee's children are in state custody.

CHAPTER 2 - HEALTH

TennCare

Almost one in four Tennesseans is covered by TennCare. More than 50,000 children ages birth to 13 who were not eligible to be covered under Medicaid are now covered by TennCare. More than 119,860 females ages 14 to 44, roughly childbearing age, are now covered and have greater access to prenatal care. A total of 385,938 people who were uninsurable or uninsured in Tennessee now have medical insurance through TennCare.

Prenatal Care, Low Birth Weight and Infant Mortality

Nearly a third of all births in Tennessee in 1992 lacked adequate prenatal care. Women who do not receive adequate prenatal care are at risk of delivering premature or low-birth-weight babies. Low birth weight is a major cause of infant mortality. There was a four percent increase from 1990 to 1992 in low-birth-weight babies born in Tennessee. In 1990, 8.2 percent of all births were infants weighing less than 5.5 pounds. In 1992, 8.5 percent of all births were of low birth weight.

Tennessee's infant mortality rate declined 54 percent from 1973 to 1991, from 20.3 per 1,000 in 1973 to 9.4 in 1992. The most recent figures show this downward trend may be accelerating. From 1990 to 1992 there was a five percent decline in Tennessee's infant mortality rate. The infant mortality rate went from 10.3 per 1,000 in 1990 to 9.8 in 1992.

The nonwhite infant mortality rate in Tennessee is more than twice as high as the white rate. The white infant mortality rate in Tennessee is 6.9 per 1,000 compared to the nonwhite rate of 16.9 per 1,000. In Tennessee, more than 99 percent of the nonwhite population is African American.

Child Deaths

There has been a 28 percent decline in the child death rate from 1980 to 1992 in Tennessee among children aged 1 through 14 years old. The rate in 1992 was 31.9 per 100,000 compared to 44 per 100,000 in 1980. Accidents are the leading cause of death - 41.5 percent of Tennessee's child deaths were caused by accidents.

Continued

Teen Pregnancy

From 1991 to 1992, there was a seven percent decrease in Tennessee's teen pregnancy rate for girls aged 10 - 17 years. In 1992, the rate was 23.8 pregnancies per 1,000 females compared to 25.6 in 1991. Decreases occurred in rates for both white and non-white females from 1991 to 1992. The white rate declined 7.9 percent from 19.1 to 17.6. The non-white rate declined 6.1 percent from 48.9 to 45.9.

Sexually Transmitted Disease Rate

A dramatic 23 percent decline occurred in the sexually transmitted disease (STD) rate for Tennessee from 1991 to 1993 for teens aged 15-19. During 1993 in Tennessee, 7,581 teens aged 15-19 were reported having STDs for a rate of 2092.0 per 100,000 while the 1991 teen STD rate was 2636.4 per 100,000.

Teen Violent Deaths

The number of teen violent deaths has increased six percent from 1984 to 1992. There were 253 teen violent deaths in 1984 compared to 269 deaths in 1992. The teen violent death rate in 1992 was 73.9 per 100,000. Approximately 90.7 percent of the 269 violent teen deaths in 1992 were due to motor vehicle accidents or firearm injuries.

Teen firearm deaths increased 135 percent from 1984 to 1992. In 1984, 12.8 percent of all teen deaths were firearm-related. By 1992 the figure had grown to 30.2 percent of all teen deaths. Sixty-eight percent of all the state's teen firearm deaths occurred in the metropolitan counties of Shelby, Davidson, Hamilton, and Knox.

CHAPTER 3 - EDUCATION

School Enrollment, Grade Retentions and Graduation Rate

Student enrollment from 1990 to 1993 increased six percent from 858,991 students in 1990 to 906,451 students in 1993. More students failed to be promoted to the next grade in 1993 after two years of continuous decline. The greatest increase in retentions was at the high school level with a 22 percent increase from 1992 to 1993. In 1992, 18,599 students were retained and in 1993 the figure was 46,299.

The number of high school graduates declined 21 percent from 1990 to 1994 while twelfth grade net enrollment increased. In 1990, there were 55,582 graduates compared to 43,564 in 1993. Twelfth grade net enrollment went from 52,795 students in 1990 to 53,258 in 1993.

School Suspensions and Expulsions

Incidents of school suspensions have risen 49 percent from 1990. There were 71,498 suspensions in 1990 and in 1993 there were 106,756 suspensions. Expulsions increased 78 percent from 1990 to 1994. In 1990 there were 397 students expelled and 709 students were expelled in 1993.

Reasons for suspensions and expulsions that have significantly increased over time include: absenteeism, tardiness, and truancy; immoral/disreputable conduct; personal violence; fighting among students; and possession of a firearm or other dangerous weapon.

Student Learning

Tennessee students are performing within the average range compared to other students in the nation. For five years, Tennessee students have scored at or above the average range on 98 percent of the nationally normed test items on the Tennessee Comprehensive Assessment Test (TCAP).

The results of the test items on TCAP that measure mastery of grade-level skills are not as encouraging. Only 57.1 percent of students in grades two through eight mastered grade-level language arts skills on the 1994 TCAP exam. Only 46.8 percent of students in grades two through eight mastered their grade-level math skills on the 1994 statewide test.

Dropping Out

Tennessee's dropout rate had a 24 percent decline from school years 1991-92 to 1992-93. The percentage of Tennessee dropouts declined from 6.3 percent in 1991-92 to 4.8 percent in 1992-93.

School Violence

There were more than five times more students expelled for possession of firearms and other dangerous weapons during the 1992-93 school year compared to 1990-91 in Tennessee. During 1990-91, there were 33 expulsions compared to 173 expulsions in the 1992-93 school year.

Chapter 1
Family and Communities

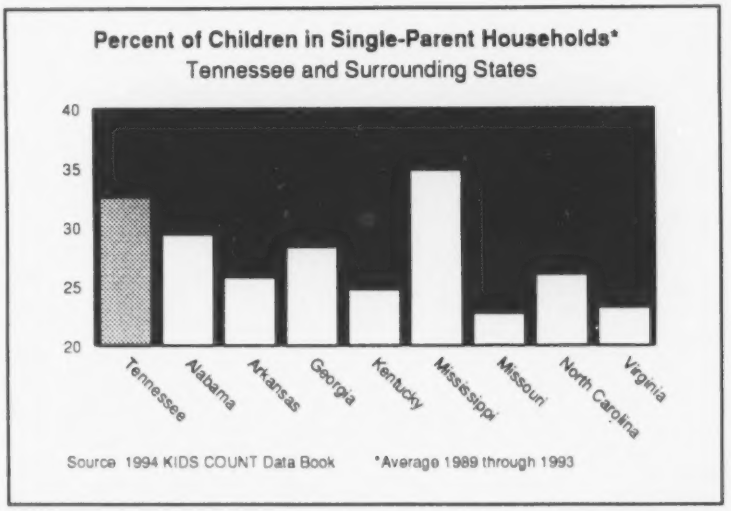
Single-Parent Families

Tennessee's Percentage Second-Worst in Nation

Nearly one-third of children in Tennessee live in single-parent families. [1] Tennessee ranks second worst in the nation in percentage of children living in single-parent families. Only Mississippi has a higher percentage. [2]

An average of 32.6 percent of Tennessee children - nearly one in three - lived in single-parent families, KIDS COUNT has calculated, using averages from 1989 through 1993. [3]

Since 1985, the percentage of Tennessee children living in single-parent families has increased by 33 percent - the fifth worst growth rate in the country. The four states with higher growth rates - Montana, Minnesota, North Dakota, and South Dakota - averaged only 19.7 percent of their children living in single-parent families. [4]



Tennessee's growth in the percentage of children living in single-parent families, while worse than the nation as a whole, nonetheless reflects a national trend. "The share of children living in single-parent families increased from 22.7 percent in 1985 to 25.1 percent in 1991 [nationally.] The increase in the percentage of children living in this type of family was pervasive. All but six states recorded an increase in this measure between 1985 and 1991." [5]

Tennessee's ranking on the percentage of children living in single-parent families is significant because many single parents lack the supports and security to provide adequately for their children. And in trying to provide financial security for their families, some single parents do not have enough emotional energy left to really nurture their children.

Also, there are significant relationships between single-parent families and poverty and single-parent families and juvenile justice involvement.

"Children growing up in single-parent households typically do not have the same economic, housing, or human resources available as those growing up in two-parent families. For example, the most recent national figures from the Census Bureau indicate that among families with children, the poverty rate for single-parent families is 42 percent, compared to 8 percent for two-parent families. Poverty among single-parent families is rarely eliminated by public assistance programs available to poor children. For example, the combination of AFDC and Food Stamps is below the poverty line in every state and under 75 percent of the poverty line in 38 states and the District of Columbia. In addition, relatively few single parents receive child support payments, and even fewer

receive the full child support payments to which they are entitled." [6]

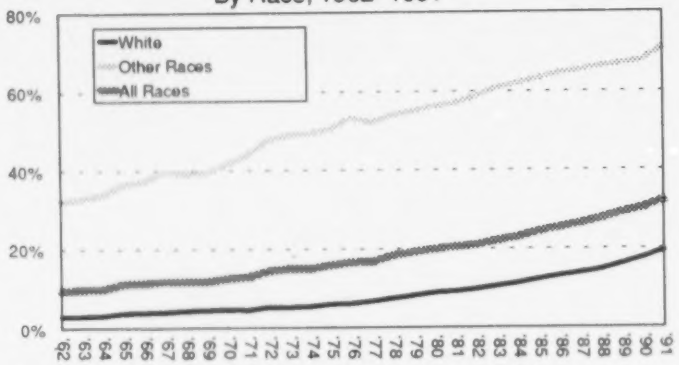
The relationship between growing up in a single-parent family and involvement with the juvenile justice system is well documented. (See Teen Crime, pages 24 through 27.)

Single-parenthood occurs in various ways: "... death of a partner, birth of a child to an unmarried mother, separation, desertion and divorce ..." [7]

It is difficult to break down what percentage of single-parent families are the result of each of these causes because, "Unlike previous censuses, the 1990 census did not ask people about their marital history ..." [8] However, it is clear that two major trends in the U.S. and Tennessee are largely responsible for the increasing rate of children living in single-parent families: the increase in nonmarital births, and the increasing number of divorces.

Tennessee Nonmarital Birth Rate

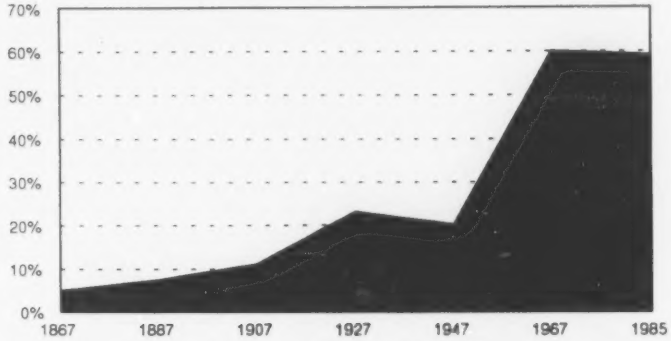
By Race, 1962 -1991



Source: Tennessee Vital Statistics 1991, Tennessee Department of Health

U.S. Divorces 1867-1985

Percent of marriages begun in each year that will end in divorce.



Source: Marriage, Divorce, Remarriage. Andrew J. Cherlin. p. 22

Number of Divorces Recorded and Persons Divorced With Rates Per 1,000 Population, Tennessee, 1982, 1991

Year	Divorces Recorded	Annual Divorce Rate
1982	29765	12.8
1983	29418	12.6
1984	29697	12.7
1985	29860	12.7
1986	30031	12.7
1987	30324	12.7
1988	31287	13
1989	31853	13.2
1990	32183	13.2
1991	33156	13.5

Source: Tennessee Vital Statistics 1991. Tennessee Department of Health

As the top chart on this page shows, nonmarital births have increased in Tennessee from 9.5 percent of all births in 1962 to 32.2 percent in 1991.

Among whites, nonmarital births increased from 3.1 percent of all births in 1962 to 19.4 percent in 1991. Among other races in Tennessee, the nonmarital birth rate climbed from 32.1 percent of all births in 1962 to 71 percent - nearly three out of four - of all births in 1991.

Necessarily, these are children who are being born into single-parent families, and most are likely to grow up in single-parent households.

The chart in the center of this page shows the dramatic rise in the U.S. divorce rate beginning in the early 1950s. The chart at the bottom of this page shows Tennessee's annual divorce rate. Since 1982, about 13 percent of all married couples in Tennessee get divorced *each year*. In 1991, 53.8 percent of those divorces involved minor children. This means that in one year alone, a total of 17,854 couples with children were divorced.

Poverty/Income

Children are Among the Poorest of the Poor in Tennessee.

In 1991, the most recent year for which state figures are available, 25.8 percent of children in the state lived in families with income below the federal poverty level. The national figure was 20 percent.

More recent national child poverty statistics have shown an increase. The U.S. Census Bureau recently reported that the number of children in poverty increased in 1993. There were 15.7 million children living in poverty in 1993, or 22.7 percent of all children. In 1992, there were 15.2 million children living in poverty - 22.3 percent of all children.

Tennessee ranked 46 out of the states in the percent of children living in poverty, according to the 1994 national Kids Count Data Book. Only Mississippi, New Mexico, Louisiana, and West Virginia ranked worse.

Several explanations as to why child poverty is increasing have been proposed. According to an official of the Children's Defense Fund, it is "much harder for young families to make ends meet than it used to be. The message here is that poverty is going to keep tightening its grip on children until parents can find stable jobs with decent pay." [1]

The Census Bureau reports that it is an odd phenomena that child poverty rates are rising during a robust economy. The rationale, according to economists, is tied into something called a 'silent depression.' As the U.S. economy "settles into a world economy and high-paying union jobs continue to disappear, more Americans are taking on lower paying service sector jobs. Although some of the problems stem from more workers forced into part-time work, that is not the whole answer. In 1979, 12 percent of full-time workers earned too little to keep a family of four out of poverty; in 1993 that rose to 16.2 percent, according to census data." [2]

In Tennessee the problem of poverty is exacerbated by the population increase in white, impoverished migrants from Georgia, Florida, and Michigan. A recent study on interstate migration revealed that from 1985 to 1990, Tennessee was among the top five states with internal migration of impoverished whites from those three states.

The percent of children in poverty is used as a well-being indicator because it is a measure for the current and future risk to children's well-being. Current risks include lack of access to basic goods and services and unsafe environments. Poor families lack the income needed to provide for their children's basic needs such as adequate food, clothing, and shelter. For example, poor children are "more likely to be malnourished; poor children aged 2-5 are almost three times more likely than non-poor to fall in the lowest percentile for height-for-age." [3]

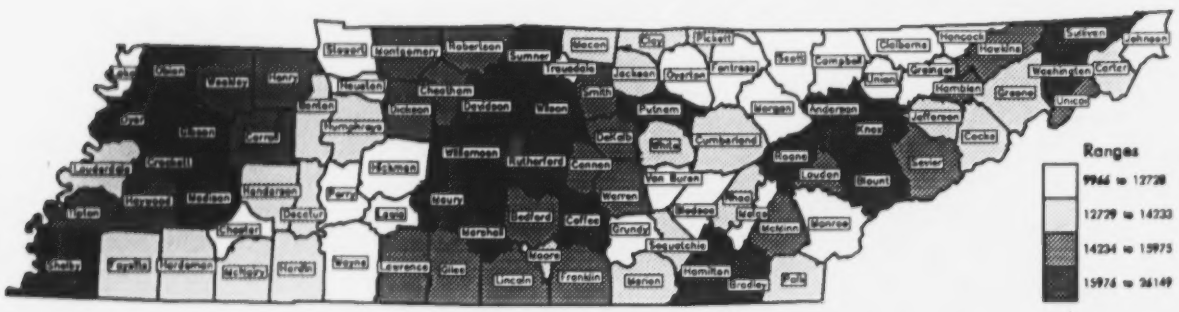
Regarding lack of access to basic services, poor families do not have access to "quality services that contribute to a child's development such as: health insurance and health services; quality day care; recreation; early childhood education. For example, poor children are less likely than non-poor to be immunized against childhood diseases, to have a regular health care provider, or to have regular physician visits." [4]

Poverty as a measure of the future risk to children's well-being includes adverse outcomes in young adulthood such as dropping out of school and teen pregnancy. Poor children are three times more likely to drop out of school. Teen girls living in poverty are five and a half times more likely to become teen mothers. Family characteristics associated with financial insufficiency include low parent education, young parental age, single-parent families, low skill levels, and lack of steady full-time employment.

Too many children in Tennessee are growing up with "parents who have relatively low education levels and little employment experience. These children are at great risk of long-term poverty and welfare dependence, especially if they live in single-parent families. A high proportion of female-headed families with children born outside of marriage rely on welfare or other forms of government assistance. Nationally, 83 percent did so from 1983 to 1986. Because childrearing with limited resources can be damaging to the child, the family, and society, the need to encourage self-sufficiency among such families is agreed upon by policymakers and citizens from a range of political perspectives. The best means for doing so, however, are currently being researched and debated." [5]

The encouraging news is that Tennessee's per capita personal income has grown faster than any other state's in the past 10 years. The state's per capita personal income increased from $9,850 in 1983 to $18,434 in 1993 - an increase of 87.1 percent. Although the state has a strong economy, the per capita income is still below the 1993 national average of $20,817. Forty-three Tennessee counties had per capita incomes below the 1991 poverty threshold for a family of four - $13,924. Note that the poverty threshold is based on household income and not per capita income.

Per Capita Personal Income by County, 1992



County	Per Capita Income* In Dollars
Anderson	18,587
Bedford	15,589
Benton	13,945
Bledsoe	11,588
Blount	17,098
Bradley	16,868
Campbell	11,846
Cannon	14,944
Carroll	14,643
Carter	13,176
Cheatham	14,743
Chester	11,673
Claiborne	12,559
Clay	13,016
Cocke	13,412
Coffee	17,429
Crockett	16,180
Cumberland	13,234
Davidson	22,273
Decatur	12,739
DeKalb	15,320
Dickson	15,583
Dyer	16,287
Fayette	14,233
Fentress	12,345
Franklin	14,586
Gibson	15,986
Giles	15,975
Grainger	11,910
Greene	13,867
Grundy	11,590
Hamblen	15,948
Hamilton	19,853
Hancock	10,150
Hardeman	13,111
Hardin	12,891
Hawkins	14,767
Haywood	15,080
Henderson	13,861
Henry	15,221
Hickman	12,728
Houston	11,640
Humphreys	14,022
Jackson	12,791
Jefferson	14,100
Johnson	9,966
Knox	19,601
Lake	11,911
Lauderdale	13,611
Lawrence	15,177
Lewis	12,592
Lincoln	14,951
Loudon	15,569
McMinn	14,394
McNairy	13,999
Macon	13,630
Madison	17,340
Marion	13,878
Marshall	17,315
Maury	16,517
Meigs	12,611
Monroe	12,602
Montgomery	14,868
Moore	13,659
Morgan	11,675
Obion	16,889
Overton	11,920
Perry	12,579
Pickett	12,970
Polk	13,152
Putnam	16,000
Rhea	13,040
Roane	16,016
Robertson	15,714
Rutherford	17,875
Scott	11,888
Sequatchie	13,245
Sevier	15,749
Shelby	20,447
Smith	15,210
Stewart	12,524
Sullivan	17,794
Sumner	17,807
Tipton	15,044
Trousdale	12,491
Unicoi	14,808
Union	11,579
Van Buren	10,157
Warren	14,510
Washington	17,199
Wayne	11,965
Weakley	14,753
White	13,221
Williamson	26,149
Wilson	18,181
Tennessee	**17,674**
U.S.A.*	**20,114**

Source: U.S. Department of Commerce, Bureau of Economic Analysis.

* Per capita personal income includes the income that is not taken into account by U.S. Census per capita personal income report.

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AFDC

AFDC Inadequate to Bring Families Out of Poverty

Today's cash welfare payments are not sufficient to bring children and their families out of poverty in Tennessee. Current AFDC payments are well below what the U.S. Department of Housing and Urban Development says is needed to rent 'decent, safe, and sanitary' housing of a 'modest' nature.

AFDC provides aid only to those poor children who fit within defined groups. AFDC provides aid for a needy child only if the child lives with a relative and one of the child's parents is dead or otherwise absent from the home, or is incapacitated or unemployed.

As a 'means tested' program, a family cannot qualify for aid unless its income is below the standards set by the state. The amount of aid provided to a family is based on the difference between its maximum net income and the 'standard of need.' In Tennessee, the standard of need is determined by the Tennessee Department of Human Services and, subsequently, adopted by the Tennessee General Assembly to become official.

The current standard of need is inadequate. Tennessee ranked 42 on the 1994 need standard for a family of three in a study by the Center on Social Welfare Policy and Law. Tennessee's standard is $426 while the average need standard in the U.S. is $657.[2]

Tennessee's 1994 AFDC benefit level for a family of three is less than half the national average. In the study by the Center on Social Welfare Policy and Law, Tennessee ranked 48 - only Alabama and Mississippi had lower benefit levels. The national average benefit level for a family of three is $393 while Tennessee's maximum is $185, less than half of the national average. [3]

Additionally, Tennessee's 1994 AFDC benefits are worth less than those in 1975. Tennessee is one of eight states where the benefit levels in January 1994 were less than they had been in January 1991. The monthly benefit levels for a family of three in Tennessee from January 1991 to January 1994 went from $195 to $185. This $10 cut was a 5.1 percent decrease. The change in the real value of monthly benefits - measuring 1994 benefits in 1991 dollars - showed a decline of $25 or 12.6 percent. [4]

Despite the declining value, there was a 65 percent increase in the monthly average number of families receiving AFDC from 1987 to 1994. The monthly average in 1987 was 63,816 families per month while the monthly average number for families on AFDC in 1994 was 105,672.

Increases in the number of caseloads have been accompanied by increases in the percent of AFDC caretakers in the work force from 12.8 percent in 1988 to 20.4 percent in 1993. However, 83.1 percent have work histories. When asked why they weren't working, over half (53.7 percent) cited disabilities, health problems, lack of child care, or their children were too young. [5]

Despite myths to the contrary, a family of three is the typical AFDC family in Tennessee; 90.4 percent of the AFDC caretakers in 1993 had three children or fewer. [6]

Another myth - that welfare recipients do not want to get off welfare - is being debunked by a state program designed to help families who receive welfare become financially independent.

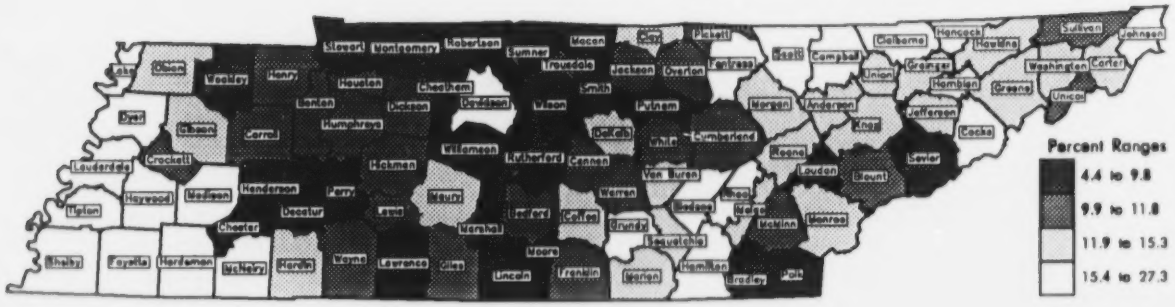
Tennessee's JOBSWORK program, administered by the Tennessee Department of Human Services and funded with federal and state dollars, helped about 62 percent of its clients who completed the program end their dependence on AFDC, a recent survey revealed.

The study, conducted by the University of Memphis, also revealed about 46 percent of JOBSWORK participants who completed the program no longer received Food Stamps; and more than 85 percent earned well above minimum wage.

Participation in JOBSWORK is not mandatory statewide. However, pilot programs in 15 Tennessee counties now require all AFDC recipients to participate in the first component of the program unless they are exempt for reasons such as having a disability, having a child less than one year old, or being under 16 or over 60 years old. The first component includes a month of training in areas such as survival skills for women, financial management, nutrition, coping with crisis, and self-advocacy. Persons who participate in the first component are encouraged to move on to the second component, which provides education or vocational training and help with finding employment.

Percent of Children Receiving AFDC

Monthly Average, Fiscal Year 1994



County	AFDC	
	Number	Percent
Anderson	2,157	13.2
Bedford	846	10.6
Benton	385	11.6
Bledsoe	445	19.2
Blount	2,091	10.3
Bradley	1,573	8.4
Campbell	2,209	25.2
Cannon	266	10.0
Carroll	675	10.3
Carter	1,480	13.1
Cheatham	692	8.4
Chester	316	9.8
Claiborne	1,107	16.6
Clay	201	12.4
Cocke	1,428	20.7
Coffee	1,312	12.3
Crockett	367	11.6
Cumberland	849	10.2
Davidson	26,280	21.4
Decatur	218	9.5
DeKalb	453	13.3
Dickson	1,119	10.8
Dyer	1,411	15.6
Fayette	1,369	18.4
Fentress	638	17.2
Franklin	889	10.3
Gibson	1,503	13.7
Giles	732	11.1
Grainger	544	13.2
Greene	1,649	13.0
Grundy	809	22.8
Hamblen	1,937	15.9
Hamilton	11,935	17.3

County	AFDC	
	Number	Percent
Hancock	445	27.3
Hardeman	1,424	21.6
Hardin	833	14.6
Hawkins	1,521	14.5
Haywood	1,142	20.9
Henderson	406	7.6
Henry	729	11.8
Hickman	484	11.7
Houston	178	10.7
Humphreys	389	10.1
Jackson	230	11.3
Jefferson	971	13.0
Johnson	472	15.6
Knox	11,431	14.5
Lake	321	22.0
Lauderdale	1,543	24.1
Lawrence	717	7.6
Lewis	255	10.8
Lincoln	638	8.8
Loudon	638	8.5
McMinn	1,174	11.4
McNairy	851	15.8
Macon	374	9.2
Madison	3,778	17.9
Marion	941	14.5
Marshall	469	8.2
Maury	1,896	12.7
Meigs	296	15.0
Monroe	1,202	15.3
Montgomery	2,597	9.0
Moore	62	5.3
Morgan	600	13.7
Obion	933	12.3

County	AFDC	
	Number	Percent
Overton	489	11.8
Perry	107	6.5
Pickett	123	11.4
Polk	304	9.7
Putnam	1,053	8.5
Rhea	1,188	19.6
Roane	1,338	12.5
Robertson	982	8.2
Rutherford	2,356	6.5
Scott	1,137	22.1
Sequatchie	350	15.1
Sevier	1,139	8.8
Shelby	60,720	25.8
Smith	295	8.3
Stewart	182	8.4
Sullivan	3,575	11.3
Sumner	1,754	5.9
Tipton	2,076	17.2
Trousdale	145	10.2
Unicoi	392	11.3
Union	572	15.2
Van Buren	153	12.7
Warren	968	11.8
Washington	2,570	12.5
Wayne	370	10.5
Weakley	607	8.0
White	503	10.4
Williamson	1,128	4.4
Wilson	1,441	7.3
Tennessee	**197,842**	**15.8**

Source: Administrative Review Section, Tennessee Department of Human Services.

Note: Percent is based on the 1993 population estimates made by Department of Sociology, University of Tennessee, Knoxville. The state average is not necessarily the sum of the county averages.

* FY 1994 is from July 1993 to June 1994.

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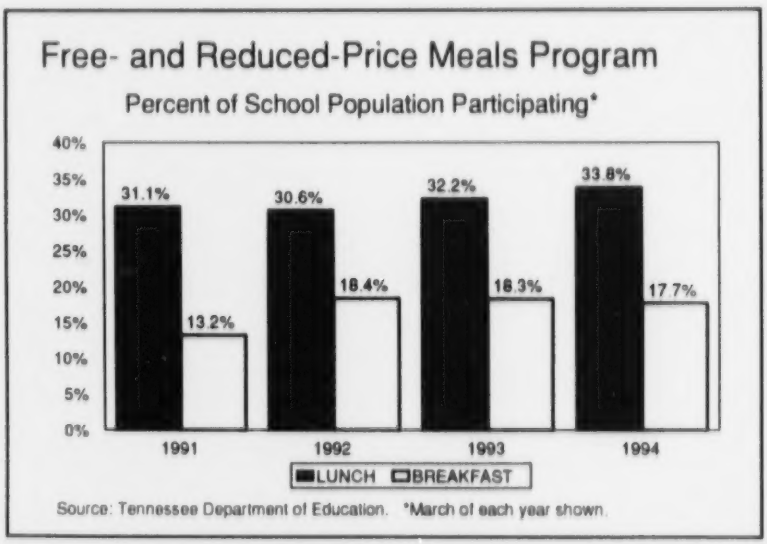
Nutrition

INADEQUATE NUTRITION MAY CAUSE LASTING DAMAGE

Inadequate nutrition, which affects the physical and cognitive development of children, may produce lasting damage to them. "Undernutrition is closely associated with poverty, and the effects of undernutrition are made worse by the range of socio-environmental insults that often accompany poverty." [1] With approximately 247,366 children living in poverty in Tennessee during 1990, thousands of them are experiencing hunger.

To protect the nutritional status of low-income children, two entitlement programs are available, the School Breakfast Program and the National School Lunch Program. These programs are open to all public and non-profit private schools and all residential child care institutions. The meals must meet specific nutritional requirements to qualify for federal funds.

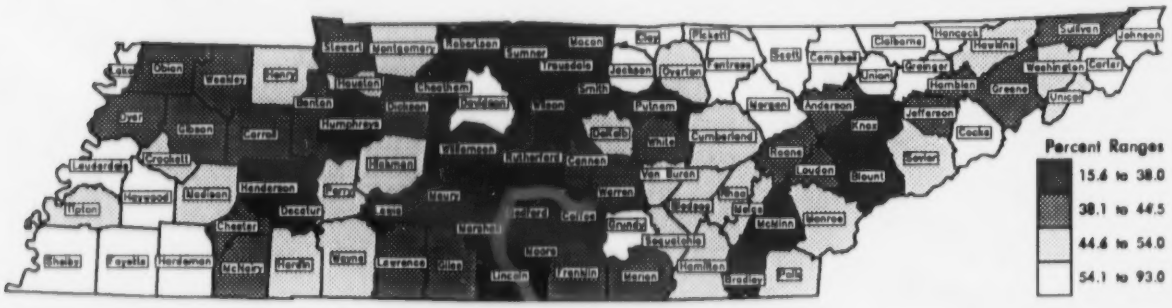
The federal government reimburses schools for all or part of the cost of every meal. The amount children pay for breakfast depends on the financial circumstances of each child's family as reflected in applications submitted to schools or other required documentation. Children from families with incomes below 130 percent of the poverty line ($18,655 for a family of four in school year 1993-94) receive meals free. Children from families with incomes between 130 and 185 percent of poverty ($26,548 for a family of four in school year 1993-94) receive meals at a reduced price. All other children receive what is officially designated a paid meal. [2]



Although the School Breakfast Program is an entitlement program, it is not available to many eligible children because some schools do not offer it. In Tennessee, the reasons most often cited for school non-participation are disruption to the school schedule or less than 50 students participate.
In Tennessee during March 1994, twice as many students participated in the lunch program as the breakfast program. During March, 248,916 low-income children participated in the National School Lunch Program while 110,959 participated in the School Breakfast Program.

Despite these disparities, Tennessee has made progress since 1991 in better low-income student participation in the breakfast program. In March

Percent of Students Participating in School Lunch Programs Who Received Lunch at Free or Reduced Prices, 1993-1994



County	Lunch	
	Number*	Percent**
Anderson	2,950	43.1
Bedford	1,410	34.0
Benton	944	44.0
Bledsoe	709	54.0
Blount	3,439	33.3
Bradley	3,109	37.5
Campbell	3,142	67.0
Cannon	567	42.0
Carroll	1,680	44.5
Carter	3,397	58.9
Cheatham	1,132	29.0
Chester	781	44.0
Claiborne	2,273	67.0
Clay	659	64.0
Cocke	2,440	63.6
Coffee	1,999	33.9
Crockett	895	44.6
Cumberland	2,354	49.0
Davidson	22,694	59.0
Decatur	605	38.0
DeKalb	857	45.0
Dickson	1,976	41.0
Dyer	2,145	42.8
Fayette	3,086	85.0
Fentress	1,416	71.0
Franklin	1,671	40.0
Gibson	2,783	42.8
Giles	1,310	39.0
Grainger	1,297	57.0
Greene	2,645	43.8
Grundy	1,022	74.0
Hamblen	2,632	42.0
Hamilton	12,126	45.1

County	Lunch	
	Number*	Percent**
Hancock	957	93.0
Hardeman	2,544	66.0
Hardin	1,375	54.0
Hawkins	2,348	46.3
Haywood	2,426	74.0
Henderson	1,048	35.9
Henry	1,612	46.1
Hickman	917	46.0
Houston	475	46.0
Humphreys	805	36.0
Jackson	648	60.0
Jefferson	1,552	39.0
Johnson	1,059	66.0
Knox	11,291	37.0
Lake	559	63.0
Lauderdale	2,742	70.0
Lawrence	2,098	40.0
Lewis	521	37.0
Lincoln	1,320	35.9
Loudon	1,689	38.4
McMinn	2,019	36.6
McNairy	1,323	43.0
Macon	818	36.0
Madison	4,783	54.0
Marion	1,404	41.0
Marshall	939	29.0
Maury	2,600	35.0
Meigs	603	54.0
Monroe	1,998	49.0
Montgomery	5,694	51.0
Moore	181	28.0
Morgan	1,407	59.0
Obion	1,658	39.7

County	Lunch	
	Number*	Percent**
Overton	1,141	52.0
Perry	384	47.0
Pickett	456	73.0
Polk	684	48.0
Putnam	2,162	37.0
Rhea	1,555	51.2
Roane	2,136	38.3
Robertson	1,895	30.0
Rutherford	4,408	29.3
Scott	2,424	77.8
Sequatchie	677	51.0
Sevier	2,808	45.0
Shelby	57,559	69.6
Smith	838	37.0
Stewart	589	44.0
Sullivan	5,687	40.5
Sumner	2,991	24.0
Tipton	3,242	46.3
Trousdale	283	31.0
Unicoi	744	48.0
Union	1,072	56.0
Van Buren	326	49.0
Warren	1,497	41.0
Washington	3,607	46.8
Wayne	953	49.0
Weakley	1,444	39.0
White	1,080	40.0
Williamson	1,342	15.6
Wilson	1,874	22.9

Tennessee	**261,994**	**48.0**

Source: School Nutrition Program, Tennessee Department of Education.

* Number of students participating in free- and reduced-price lunch program.

**Percent is the number of students getting free or reduced price lunches divided by the total number of students participating in school lunch programs.

1991, there were 102,307 participants (13.2 percent of the total school population) compared to 115,399 in March 1994, (17.7 percent of the total school population). To reach more children, Tennessee applied for and received federal start-up funds in 1994 to encourage the initiation of school breakfast programs.

Research on the benefits of the School Breakfast Program shows that children who participated had significantly higher standardized achievement test scores than eligible non-participants. [3] "Children getting school breakfast also had significantly reduced absence and tardiness rates." [4]

Raising test scores and improving attendance are only two reasons why the breakfast and lunch programs are essential. The United States Dairy Association (USDA) research on the National School Lunch Program shows that children who participate in the lunch program have "superior nutritional intake compared to those who do not. Studies also show that low-income children depend on the School Lunch Program for one-third to one-half of their nutritional intake each day. These findings indicate that this program is highly significant insofar as protecting the nutritional status of most participating low-income children." [5]

According to the 1994 Tufts study, *The Link Between Nutrition and Cognitive Development in Children*, recent research provides "compelling evidence that undernutrition during any period of childhood can have detrimental effects on the cognitive development of children and their later productivity as adults. In ways not previously known, undernutrition impacts the behavior of children, their school performance, and their overall cognitive development. These findings are extremely sobering in light of the existence of hunger among millions of American children." [6]

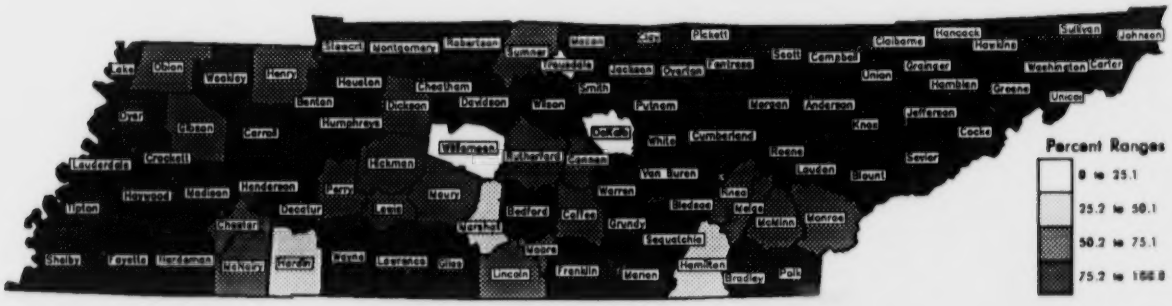
Even short-term nutritional deficiencies can "influence children's behavior, ability to concentrate, and to perform complex tasks. Deficiencies in specific nutrients, such as iron, have an immediate effect on the ability to concentrate. Child hunger, defined by inadequate nutrition intake during the early years, is capable of producing progressive handicaps - impairments which can remain throughout life." [7]

The Tufts study provides evidence which suggests that undernutrition "costs far more than the diminished well-being of youngsters during childhood. By robbing children of their natural human potential, undernutrition results in lost knowledge, brain power and productivity for the nation. The longer and more severe the malnutrition, the greater the likely loss and the greater the cost to our country." [8]

CHILD NUTRITION PROGRAMS - INCOME GUIDELINES FOR CHILD NUTRITION PROGRAMS 1993-1994

Size of Household	Free Meals - 130% of Poverty			Reduced-Price Meals - 185% of Poverty		
	Year	Month	Week	Year	Month	Week
1	$9,061	$756	$175	$12,895	$1,057	$248
2	$12,259	$1,022	$236	$17,446	$1,454	$336
3	$15,457	$1,289	$298	$21,997	$1,834	$424
4	$18,655	$1,555	$359	$26,548	$2,213	$511
5	$21,853	$1,822	$421	$31,099	$2,592	$599
6	$25,051	$2,088	$482	$35,650	$2,971	$686
7	$28,249	$2,355	$544	$40,201	$3,351	$774
8	$31,447	$2,621	$605	$44,752	$3,730	$861
Each additional	$3,198	$267	$62	$4,551	$380	$88

Percent of Students Participating in School Lunch Programs for Whom School Breakfast Programs Were Available, 1993-1994



County	Breakfast Percent
Anderson	100.0
Bedford	86.2
Benton	76.0
Bledsoe	100.0
Blount	87.2
Bradley	100.2
Campbell	100.0
Cannon	71.9
Carroll	90.6
Carter	100.0
Cheatham	100.0
Chester	72.6
Claiborne	99.9
Clay	100.0
Cocke	97.7
Coffee	58.2
Crockett	100.0
Cumberland	100.0
Davidson	78.4
Decatur	76.1
DeKalb	17.5
Dickson	65.5
Dyer	82.6
Fayette	100.0
Fentress	99.9
Franklin	81.9
Gibson	67.7
Giles	100.0
Grainger	100.0
Greene	77.7
Grundy	100.0
Hamblen	78.9
Hamilton	49.3

County	Breakfast Percent
Hancock	100.0
Hardeman	100.0
Hardin	48.5
Hawkins	100.0
Haywood	100.0
Henderson	100.0
Henry	65.1
Hickman	71.9
Houston	100.0
Humphreys	77.1
Jackson	100.0
Jefferson	100.0
Johnson	100.0
Knox	100.0
Lake	100.0
Lauderdale	100.0
Lawrence	100.0
Lewis	70.9
Lincoln	63.4
Loudon	99.8
McMinn	66.7
McNairy	63.4
Macon	77.5
Madison	100.0
Marion	79.4
Marshall	46.9
Maury	50.4
Meigs	67.4
Monroe	56.4
Montgomery	100.0
Moore	51.1
Morgan	100.0
Obion	65.2

County	Breakfast Percent
Overton	100.0
Perry	70.8
Pickett	100.0
Polk	100.0
Putnam	100.0
Rhea	56.1
Roane	100.0
Robertson	76.6
Rutherford	64.0
Scott	100.0
Sequatchie	100.1
Sevier	100.0
Shelby	80.5
Smith	100.0
Stewart	100.0
Sullivan	89.2
Sumner	57.7
Tipton	88.8
Trousdale	0.0
Unicoi	100.0
Union	100.0
Van Buren	100.0
Warren	100.0
Washington	100.0
Wayne	100.0
Weakley	82.6
White	100.0
Williamson	24.6
Wilson	98.6

Tennessee	**81.8**

Source: School Nutrition Program, Tennessee Department of Education.

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Teen Employment

Teen Employment has Advantages, Disadvantages

Is teen employment good or bad for teens who are in school? What are the advantages and disadvantages of teen employment?

Two of the benefits to teens who take part-time jobs while in school are the opportunity to develop personal responsibility for assigned duties and to become more self-reliant. Teens with jobs in retail sales and other jobs that require extensive social interaction learn to deal more effectively with other people and co-workers. Working also contributes to the acquisition of knowledge about business matters, financial concepts, consumer matters, and loyalty to a company. [1]

Another important benefit of working is for teens to learn different socialization skills from those they learn in school. "Schools are not equipped to train youth in the non-academic skills of being an adult, which include learning to take responsibility for self-management, learning how to function in activities that have implications for other people, acquiring the ability to take decisive actions and learning to work." [2]

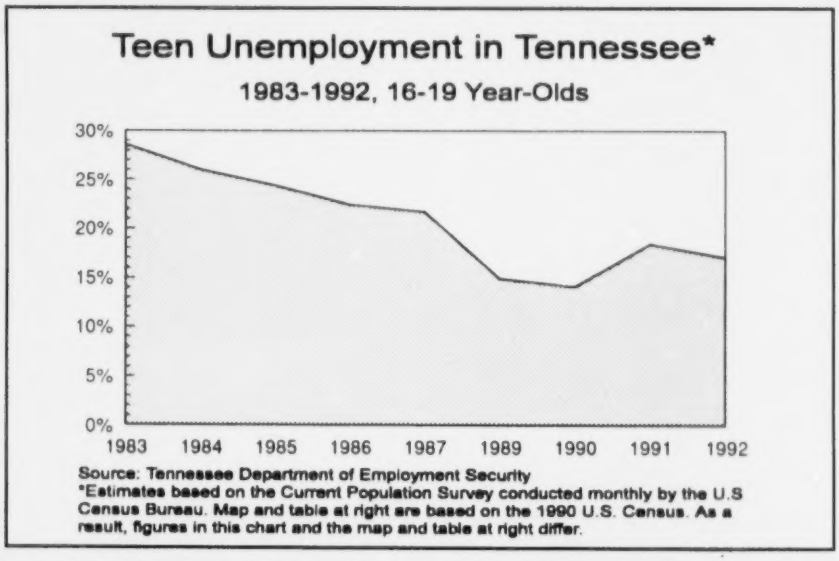
Detrimental aspects of working can be observed in teens who work more than 20 hours a week. Some of the negative effects are decreased involvement in extracurricular activities, declining grades, and physical fatigue. In some cases, students reported that the demands of school and workplace made them hate school and want to quit. There is substantial evidence that high levels of job stress or long working hours can lead to increased cigarette, alcohol, and marijuana use. [3]

Another negative effect of teen employment is that excessive commitment to a job may interfere with the work of growing up. This results when adolescents spend too much time and energy "in a role that is too constraining and involves tasks that are too simple, unchallenging, and irrelevant to their future to promote development. By spending too much time working, teens may be passing up equally rigorous, but unpaid, work of growing up - work that requires exploration, experimentation, and introspection." [4]

Clearly, it is debatable whether employment is good or bad for teens. The answer undoubtedly depends on the teen and his or her maturity, economic need and the nature of his or her employment.

The chart below shows teen unemployment rates based on monthly Census Bureau estimates, which are useful for observing trends. It shows unemployment rates for teens 16 to 19 years old who are available for work and actively seeking work. Teen unemployment dropped steadily from 28.6 percent in 1983 to 14.1 percent in 1990. The teen unemployment rate then increased to 18.4 percent in 1991 and declined slightly to 17.1 percent in 1992.

The map and table on the next page contain figures based on the 1990 Census, which, though different from the data in the chart below, are nonetheless useful for observing recent conditions.



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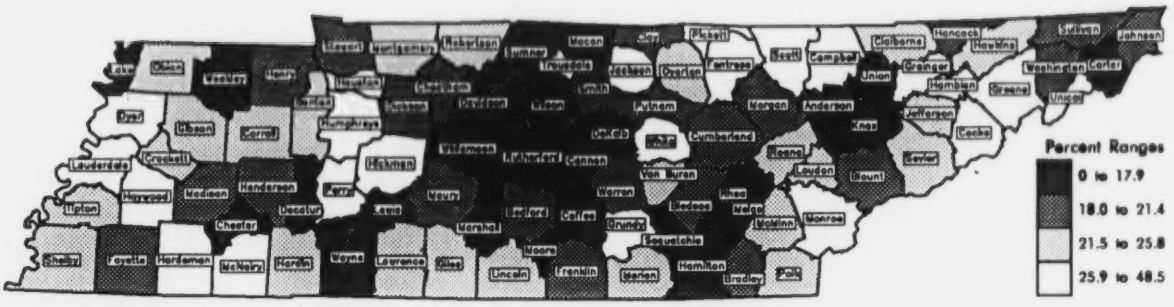
Youth Unemployment Rate (Ages 16-19)*, 1993

Note: This rate is percent.



County	Youth Unemployment	
	Number	Percent
Anderson	340	16.9
Bedford	190	19.0
Benton	100	22.2
Bledsoe	40	21.1
Blount	440	18.7
Bradley	560	21.4
Campbell	330	32.0
Cannon	10	4.0
Carroll	170	22.1
Carter	260	17.8
Cheatham	140	20.0
Chester	50	10.0
Claiborne	190	22.9
Clay	40	19.0
Cocke	310	30.7
Coffee	160	14.7
Crockett	100	25.0
Cumberland	210	20.0
Davidson	2,210	16.5
Decatur	50	17.9
DeKalb	80	16.3
Dickson	190	19.6
Dyer	300	26.8
Fayette	110	20.4
Fentress	150	28.3
Franklin	220	20.2
Gibson	270	23.1
Giles	180	23.1
Grainger	150	28.8
Greene	660	37.3
Grundy	100	31.3
Hamblen	560	29.9
Hamilton	1,300	17.1

County	Youth Unemployment	
	Number	Percent
Hancock	20	18.2
Hardeman	200	32.8
Hardin	190	24.7
Hawkins	320	25.6
Haywood	210	40.4
Henderson	120	18.5
Henry	170	18.1
Hickman	160	32.0
Houston	70	43.8
Humphreys	140	31.8
Jackson	70	26.9
Jefferson	270	23.1
Johnson	80	21.1
Knox	1,400	13.8
Lake	30	17.6
Lauderdale	320	48.5
Lawrence	280	23.1
Lewis	40	13.8
Lincoln	230	25.8
Loudon	220	22.0
McMinn	320	25.4
McNairy	190	30.6
Macon	80	16.3
Madison	460	18.3
Marion	170	23.3
Marshall	80	11.3
Maury	340	18.3
Meigs	30	12.0
Monroe	270	26.7
Montgomery	590	21.9
Moore	0	0.0
Morgan	50	19.2
Obion	200	22.0

County	Youth Unemployment	
	Number	Percent
Overton	150	24.2
Perry	40	33.3
Pickett	30	30.0
Polk	90	25.0
Putnam	390	19.4
Rhea	130	17.6
Roane	300	24.6
Robertson	360	24.8
Rutherford	780	16.7
Scott	160	39.0
Sequatchie	50	17.9
Sevier	440	24.3
Shelby	4,800	23.2
Smith	80	18.2
Stewart	50	20.0
Sullivan	780	20.9
Sumner	590	17.1
Tipton	220	21.8
Trousdale	50	33.3
Unicoi	150	37.5
Union	50	14.7
Van Buren	30	25.0
Warren	230	20.2
Washington	560	19.0
Wayne	50	11.1
Weakley	150	11.5
White	190	33.9
Williamson	250	11.5
Wilson	350	16.7

Tennessee	**29,000**	**20.6**

Note: * Youth unemployed rate is the number of persons unemployed ages 16-19 years old, expressed as percent of labor force ages 16-19. Youth unemployed are those who are 16-19 years old and don't have a job but are available for work and actively seeking work. The numbers are the estimates based on 1990 U.S. Census population data.
Source: Tennessee Department of Employment Security.

21

Domestic Violence

Domestic Violence Impacts Children in Many Ways

Domestic violence is not just between adults.

Official crime statistics tell the tales of battered babies, assaultive siblings and beaten wives. Brothers and sisters "beat, stab, and shoot each other. There are husbands who are struck and beaten by their wives, and even grandparents are battered by their own children. Violence in one generation affects and encourages violence in another generation. In many families, perhaps a majority of violent families, violence is not even considered taboo or wrong. Rather it is an acceptable and integral part of the way a family functions." [1]

The belief that all family life is safe and secure has been shattered by those who have pointed out the alarming frequency of various violent incidents in many American families. Family violence crosses all socioeconomic, geographical, and religious distinctions. It occurs in all age brackets, regardless of one's ethnic group, state of sobriety, or education. [2]

This topic was once considered either a family secret or acceptable behavior within a patriarchal society. Extensive research by social scientists has suggested that family violence is widespread and is interwoven with the very fabric of society's attitudes and values. [3] Now, graphic media coverage of celebrated cases and regular discussions on the most widely seen television programs are commonplace. [4]

Unfortunately, domestic violence may be underreported because many women fail to report incidents of violence. According to many criminologists, battered, abused victims often may be too fearful and demoralized to reach out for help; also the criminal justice system is more trained to apprehend and deal primarily with perpetrators of street crimes than domestic conflicts. For example, until recently, domestic disputes were considered to be routine calls by the police. Increasingly, however, "these family problems have spilled into the courts as assault, aggravated assaults, and murder. And as the cycle of family violence has continued, young children have adopted their parents' methods for dealing with discord - and often with devastating effects. School counselors and social workers now claim that domestic strife has resulted in school and street violence, as these children and youth carry their problems - and weapons - into society." [5]

It is estimated that between 2 to 4 million American women each year are abused in their homes. [6] Six out of every ten married couples have experienced violence at some time during their marriage.

Domestic violence may touch as many as one fourth of all American families. [7] Many researchers, however, believe that this figure 'substantially underrepresents the extent of violence in American families, perhaps by half.' Others estimate that physical assault occurs in nearly one-third of American families.' Lenore Walker, author of *The Battered Woman*, holds that 'as many as fifty percent of all women will be battering victims at some point in their lives." [8]

Many children are present to witness this violence. It is estimated that at least 3.3 million children in the U.S. between the ages of 3 and 17 years are at risk of exposure to parental violence. [9] Children may witness domestic violence directly or indirectly. A child may observe this violence directly by seeing father (or another intimate partner of mother) threaten or hit mother.

Children may overhear this behavior from another part of the home, such as their own bedroom. They may be exposed to the results of this violence without hearing or seeing the commission of any aggressive act. For example, children may see

the bruises or other injuries clearly visible on their mothers or the "emotional consequences of fear, hurt, and intimidation that may be very apparent to them. Less commonly, children may be exposed to isolated incidents of violence, although these cases are unlikely to come to the attention of police or other social service professionals. In too many cases, these children have observed repeated acts of violence perpetrated by multiple partners throughout their entire childhood." [10]

Children who live in violent homes are psychologically abused and may be verbally, physically, and sexually abused. Children from violent homes are characterized by:

•constant fear, terror, confusion and insecurity;
• increasing deceptiveness: lying, excuses for outings, stealing, cheating;
• poor definition of personal boundaries, violation of others personal boundaries, accepting blame or projecting blame;
• little or no understanding of the dynamics of violence; often assumes violence to be the norm: self-blame (depending on age) for family feuding, separations, divorce, and internal conflicts;
• continuation of abuse patterns in adult life;
• frequently participating in pecking order battering (maim or kill animals, batter siblings); often batter parents in later years;
• poor problem solving skills: may use violence as problem solving technique in school, with peers, with family demonstrates aggression or passivity;
• poor sexual image, uncertainly about appropriate behavior, confused model identification, immaturity in peer relationships;
• being at higher risk for assaults;
• heightened suicide risks and attempts - increased thoughts of suicide and/or murdering parents, prone to negligence and carelessness;
• feeling used and powerless. [11]

Some children suffer permanent psychological damage from experiencing violence in their home. Others face physical injury as well when they are abused themselves or "caught in the cross fire of their fathers' violence." [12]

Many researchers have noted a significant overlap between wife assault and child abuse. There is reason to suspect that many children suffer from repeated exposure to violence, both as direct and indirect victims." [13]

Children are at high risk of suffering physical abuse in homes where domestic violence occurs. Even if they are not physically abused themselves, children who witness domestic violence suffer very similar psychological trauma associated with children who are physically abused. [14]

Children are at high risk of suffering physical abuse themselves in homes where domestic violence occurs. Even if they are not physically abused themselves, children who witness domestic violence suffer very similar psychological trauma associated with children who are physically abused.

The abusive family typically has a "rigid boundary between family and the outside world" and a strong belief that a man's power within his family is not subject to outside surveillance or checks." [15] Wife and child battering provide other examples of how traditional values can go wrong. Research studies have shown that abusive families are "marked by constant competition over who will be taken care of." [16] This suggests that abuse is sometimes an extension of demands for privacy, intimacy, and individual fulfillment through the family. Battering often occurs in the "most private parts of the house; it tends to be triggered by very traditional demands from the man and perpetuated by passive rather than assertive responses by the woman." [17] Infants may suffer serious unintended consequences when raised in an environment of wife abuse. "Their basic needs for attachment to their mother may be significantly disrupted. A mother living in fear of her husband may be unable to handle the stressful demands of an infant. Clearly, an infant will recognize this distance and lack of availability of his or her principal caretaker. Infants and toddlers may also be injured in a violent episode by being caught in the cross fire. They may be accidentally hit, pushed or dropped during a violent outburst, or their mother may hold them for their own safety but discover that their father has no regard for their physical and emotional vulnerability." [18]

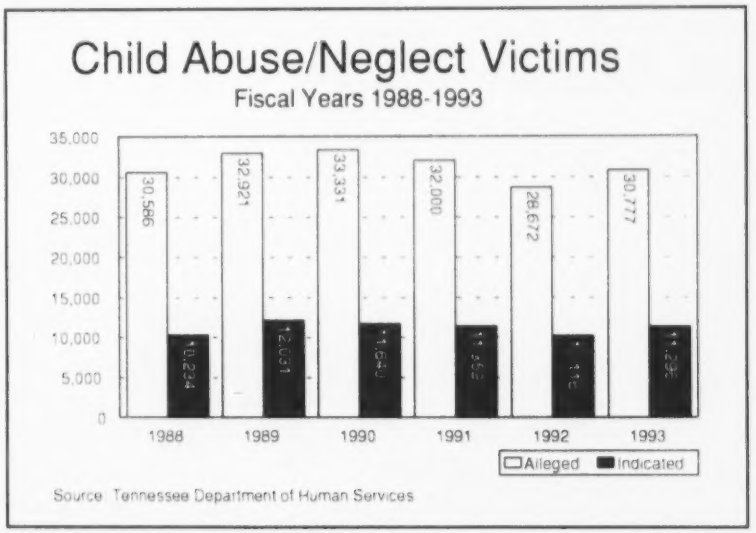
Child Abuse

Majority Abused by Family Members

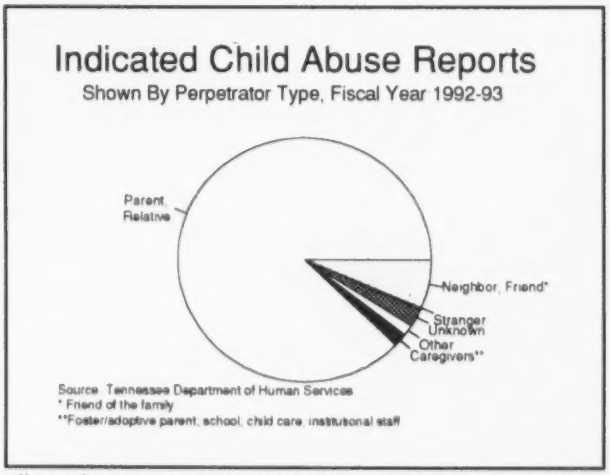
More than 11,000 Tennessee Children Abused or Neglected in '93

"Child abuse and neglect occur when a child is mistreated, resulting in injury or risk of harm. Abuse can be verbal, emotional or sexual." [1]

In Fiscal Year 1993 in Tennessee "...evidence was found that 11,296 children were abused and/or neglected ... Twenty-two percent of all reports involved children from birth through two years of age ... Of all indicated reports of abuse and/or neglect, 66 percent of the child victims were abused/neglected by their natural parents." [2]



As the chart (right) shows, roughly a third of allegations are considered indicated each year, and the number of indicated victims has not changed significantly in recent years.


Indicated Child Abuse Reports
Shown By Perpetrator Type, Fiscal Year 1992-93
Parent, Relative
Neighbor, Friend*
Stranger Unknown
Other Caregivers**
Source: Tennessee Department of Human Services
* Friend of the family
**Foster/adoptive parent, school, child care, institutional staff

Allegations of child abuse or neglect must be made to the Tennessee Department of Human Services (DHS) directly, or to law enforcement or juvenile courts, who then notify DHS.

DHS investigations are pursued in the following cases:
1) reports alleging physical abuse or neglect of children from birth to 18 years;
2) reports alleging sexual abuse of children from birth to 12 years; and
3) reports alleging sexual abuse of children 13 to 18 years old, provided that the alleged perpetrator is a relative, caretaker, or someone residing in the home. [3]

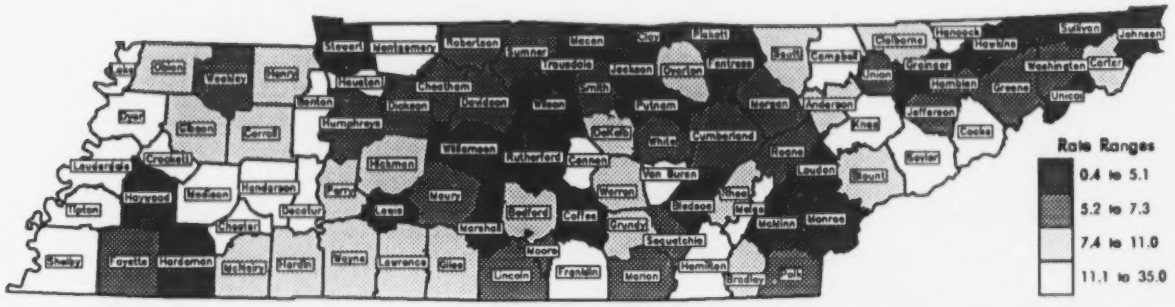
Children are removed from their homes during the investigation only "if needed to protect the child," *Child Protective Services A Parents' Guide*, a DHS brochure, says. "In many cases this does not happen and the child can stay in his or her home," the brochure says. "Sometimes, if needed to protect the child, [the parents and/or other adults in the home], relatives and DHS can work out a plan for the child to live with relatives for a while during the investigation. A child is placed in temporary foster care ... by court order only if it is the only way to protect the child."

After an investigation is conducted by DHS, a particular case is determined indicated or unfounded. If the investigation concludes that an incidence of abuse occurred, the case is declared "indicated." If the investigation concluded that it did not occur, it is "unfounded."

If the report is declared indicated, DHS arranges for services needed to protect and help the child. Services will also be arranged to help adults in the home so that the child may remain in the home, or, if the child has been removed, so that he or she can be returned to his or her home.

Indicated Child Abuse & Neglect Rate*, 1992-1993

Note: This rate is Per 1,000, NOT percent.



County	Child Abuse	
	Number	Rate
Anderson	133	8.1
Bedford	84	10.6
Benton	45	13.6
Bledsoe	1	0.4
Blount	167	8.3
Bradley	159	8.6
Campbell	110	12.4
Cannon	45	17.0
Carroll	57	8.7
Carter	95	8.4
Cheatham	52	6.5
Chester	40	12.4
Claiborne	54	8.1
Clay	6	3.7
Cocke	121	17.5
Coffee	54	5.1
Crockett	45	14.1
Cumberland	43	5.2
Davidson	891	7.3
Decatur	57	24.5
DeKalb	27	7.9
Dickson	60	5.9
Dyer	106	11.8
Fayette	41	5.5
Fentress	19	5.1
Franklin	105	12.1
Gibson	115	10.4
Giles	58	8.8
Grainger	20	4.8
Greene	92	7.2
Grundy	31	8.6
Hamblen	69	5.7
Hamilton	780	11.3

County	Child Abuse	
	Number	Rate
Hancock	58	35.0
Hardeman	26	3.9
Hardin	58	10.2
Hawkins	54	5.1
Haywood	10	1.8
Henderson	84	15.6
Henry	65	10.4
Hickman	40	9.8
Houston	34	20.3
Humphreys	27	6.9
Jackson	5	2.4
Jefferson	48	6.4
Johnson	12	3.9
Knox	1,010	12.9
Lake	24	16.2
Lauderdale	119	18.6
Lawrence	72	7.7
Lewis	9	3.8
Lincoln	49	6.8
Loudon	34	4.6
McMinn	50	4.8
McNairy	56	10.3
Macon	14	3.5
Madison	274	13.0
Marion	42	6.5
Marshall	16	2.8
Maury	92	6.3
Meigs	24	12.1
Monroe	26	3.3
Montgomery	318	11.2
Moore	8	6.7
Morgan	24	5.5
Obion	65	8.5

County	Child Abuse	
	Number	Rate
Overton	42	10.0
Perry	16	9.7
Pickett	6	5.5
Polk	19	6.0
Putnam	56	4.6
Rhea	61	10.0
Roane	79	7.3
Robertson	73	6.2
Rutherford	41	1.2
Scott	43	8.3
Sequatchie	14	6.0
Sevier	156	12.3
Shelby	3,003	12.9
Smith	19	5.4
Stewart	5	2.3
Sullivan	141	4.4
Sumner	168	5.7
Tipton	179	15.1
Trousdale	5	3.5
Unicoi	4	1.1
Union	23	6.2
Van Buren	25	20.3
Warren	91	11.0
Washington	139	6.8
Wayne	33	9.3
Weakley	51	6.7
White	35	7.3
Williamson	52	2.1
Wilson	88	4.5

Tennessee	**11,296**	**9.1**

Source: Tennessee Department of Human Services.

* Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

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Teen Crime

Is There a Teen Crime Wave in Tennessee?

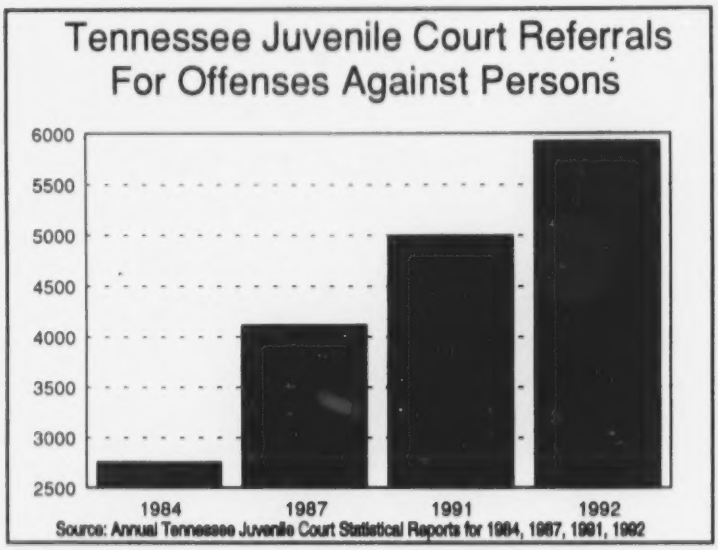
Throughout the nation the media have recently focused on teen crime. Legislatures have proposed numerous revisions in juvenile and criminal law to reduce a teen crime wave that is believed to be sweeping the country.

Tennessee is no exception. More than 50 juvenile-crime-related bills were introduced in the Tennessee General Assembly during the 1993-94 session.

Some have argued that the public has been misled by a media feeding frenzy about juvenile crime. The fundamental question to answer regarding teen crime is whether Tennessee teens are committing more crimes now than a decade ago.

The answer is yes.

Since 1984, the number of referrals to juvenile courts in Tennessee for violent crimes has more than doubled, according to annual statistical reports of the Tennessee Council of Juvenile and Family Court Judges [1], while the population of teens in Tennessee has decreased. In 1984, a total of 2,753 referrals were made to juvenile courts for offenses against persons. In 1992, the latest year for which figures are available, 5,926 referrals were made for the same offenses, the *1992 Annual Statistical Report* of the Council of Juvenile and Family Court Judges says. [2]



Referrals are allegations, and each youth may be referred several times, so the referral figures do not represent the number of youths charged with offenses, but rather the number of offenses charged.

The table below presents the number of referrals for offenses against persons in 1984, 1987, 1991, and 1992. Most categories show increases. Rape and assault to murder reflect decreases. The reductions in assault to murder may be correlated with the increasing

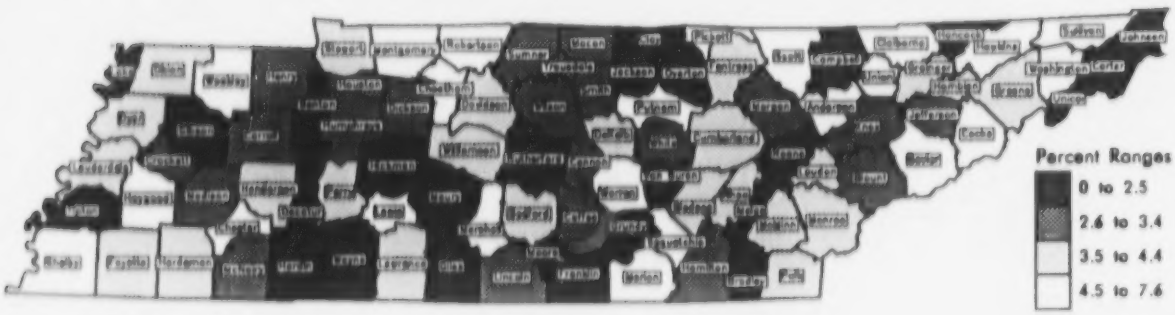
Tennessee Juvenile Court Referrals for Offenses Against Persons, 1984-1992

OFFENSES	1984	1987	1991	1992
MURDER	40	40	79	111
MANSLAUGHTER	18	11	35	66
ROBBERY WITH A DEADLY WEAPON	118	202	231	304
ROBBERY	170	220	166	227
ASSAULT TO MURDER	78	126	38	38
ASSAULT	1962	2963	4147	4794
RAPE	157	297	124	147
ASSAULT TO RAPE	30	33	32	42
SEX OFFENSES (except rape, prostitution)	172	205	143	187
VEHICULAR HOMICIDE	8	15	15	10
TOTAL	2753	4112	4994	5926

Source: Annual Tennessee Juvenile Court Statistical Reports for 1984, 1987, 1991, and 1992.

26

Percent of Children* Referred to Juvenile Courts, January 1992 - December 1992



County	Referrals	
	Number	Percent
Anderson	824	5.0
Bedford	302	3.8
Benton	51	1.5
Bledsoe	84	3.6
Blount	672	3.3
Bradley	391	2.1
Campbell	98	1.1
Cannon	69	2.6
Carroll	178	2.7
Carter	185	1.6
Cheatham	397	4.9
Chester	148	4.6
Claiborne	298	4.5
Clay	32	2.0
Cocke	380	5.5
Coffee	345	3.3
Crockett	95	3.0
Cumberland	346	4.2
Davidson	4,792	3.9
Decatur	34	1.5
DeKalb	123	3.6
Dickson	317	3.1
Dyer	391	4.3
Fayette	270	3.6
Fentress	141	3.8
Franklin	185	2.1
Gibson	271	2.5
Giles	138	2.1
Grainger	164	4.0
Greene	537	4.2
Grundy	31	0.9
Hamblen	529	4.4
Hamilton	1,975	2.9

County	Referrals	
	Number	Percent
Hancock	22	1.3
Hardeman	264	4.0
Hardin	143	2.5
Hawkins	646	6.2
Haywood	250	4.5
Henderson	187	3.5
Henry	166	2.6
Hickman	99	2.4
Houston	52	3.1
Humphreys	110	2.8
Jackson	18	0.9
Jefferson	241	3.2
Johnson	48	1.6
Knox	2,268	2.9
Lake	35	2.4
Lauderdale	278	4.3
Lawrence	340	3.6
Lewis	153	6.4
Lincoln	201	2.8
Loudon	285	3.8
McMinn	377	3.6
McNairy	184	3.4
Macon	119	2.9
Madison	636	3.0
Marion	291	4.5
Marshall	378	6.7
Maury	182	1.2
Meigs	38	1.9
Monroe	327	4.2
Montgomery	1,465	5.2
Moore	20	1.7
Morgan	116	2.6
Obion	286	3.7

County	Referrals	
	Number	Percent
Overton	48	1.1
Perry	68	4.1
Pickett	57	5.2
Polk	134	4.2
Putnam	751	6.1
Rhea	255	4.2
Roane	193	1.8
Robertson	651	5.5
Rutherford	745	2.1
Scott	259	5.0
Sequatchie	121	5.2
Sevier	644	5.1
Shelby	14,535	6.2
Smith	95	2.7
Stewart	79	3.7
Sullivan	1,802	5.6
Sumner	846	2.9
Tipton	302	2.5
Trousdale	49	3.4
Unicoi**	0	0.0
Union	253	6.8
Van Buren	5	0.4
Warren	447	5.4
Washington	1,559	7.6
Wayne	83	2.3
Weakley	426	5.6
White	139	2.9
Williamson	1,091	4.4
Wilson	595	3.1
Tennessee	**51,250**	**4.1**

Note: * For children under 18 years old
** Unicoi County is not in the system.
Source: 1992 Annual Statistical Report, Council of Juvenile and Family Court Judges, 1993.

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lethality of juvenile conflict and consequently the increase in murder referrals.

Having established that teen violent crime is increasing, the next question is why?

The American Psychological Association (APA), in its publication *Violence & Youth: Psychology's Response*, identifies factors that are strong predictors of violent behavior.

Lack of parental supervision is one of the strongest predictors, the report says. [3] Other parental factors include parents supporting aggressive behavior by children, failing to teach nonviolent methods of solving social problems, and inconsistent, harsh and continued physical punishment. [4]

Poverty, with its "sense of relative deprivation and ... lack of opportunity ... facilitates higher rates of violence," the report says. [5]

Among the ways poverty leads to violence, the report says, are poverty's effect of discouraging family stability; inadequate nutrition, medical care and emotional support; and neighborhood instability. [6]

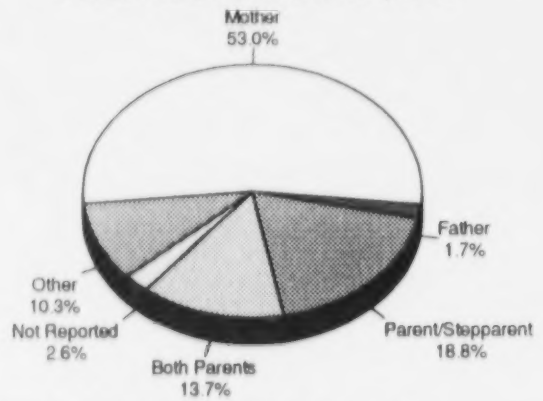
While race would appear to be a factor - about 59 percent of crimes against persons committed by male juveniles were committed by African-American males in 1992 [7], even though 20.7 percent of Tennessee's under-18 population is African American [8] - "...it is very likely that socioeconomic inequality - not race - facilitates higher rates of violence among ethnic minority groups," [9] the APA report says. "Few differences among the races are found in rates of violence when people at the same socioeconomic level are compared."

However, race *can* be a factor in violence when prejudice and discrimination "damage the self-confidence and self-esteem of those discriminated against and lay a foundation for anger, discontent, and violence." [10]

Single parenthood may be another factor. There is a significant relationship between single-parent families, poverty, and juvenile justice involvement.

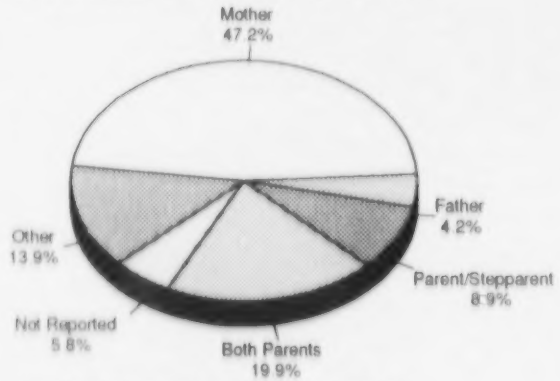
National figures prepared by the Population Reference Bureau (PRB) in its publication *The Challenge of Change* show a relationship between single-parent families

LIVING ARRANGEMENTS OF CHILDREN REFERRED TO JUVENILE COURT REFERRALS FOR MURDER, 1992



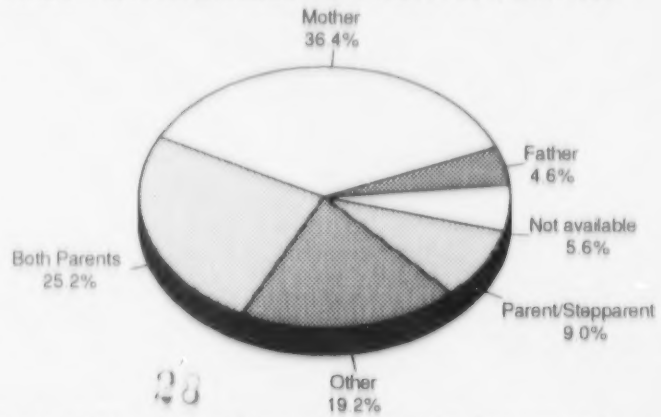
Source: Tennessee Council of Juvenile and Family Court Judges

LIVING ARRANGEMENT OF CHILDREN REFERRED TO JUVENILE COURT OFFENSES AGAINST PERSONS, 1992



Source: Tennessee Council of Juvenile and Family Court Judges

LIVING ARRANGEMENTS OF ALL CHILDREN REFERRED TO JUVENILE COURT THREE-YEAR AVERAGES FOR 1989, 1991, and 1992



Source: Annual Juvenile Court Statistical Reports for 1989, 1991, and 1992.

and poverty. In 1990, 79.6 percent of single-parent families lived in poverty, according to the PRB report. [11]

Tennessee figures confirm a relationship regarding single-parenthood and juvenile justice involvement. In 1992, only 13.7 percent of (16 of the 107) juveniles referred for murder in Tennessee lived with both parents, Tennessee Council of Juvenile and Family Court Judges research shows (see chart). A slight majority, 53 percent, lived only with their mothers.

For all crimes against persons in Tennessee in 1992, 19.9 percent of juveniles referred lived with both parents, while 47.2 percent lived with their mothers (see chart).

Three-year averages of children referred to juvenile court (see chart) for *all* offenses, including non-violent and property offenses, show a smaller percentage, 36.4 percent, of children referred to juvenile courts lived with their mothers only compared to those referred for violent crimes. Also, a larger percentage of children referred for all offenses, 25.2, lived with both parents. This indicates that children and youth who live with their mothers only are more likely to commit violent crimes than the population of all children and youth referred to juvenile courts. The variations in percentages for each of the three years averaged are less than one percent.

The "other" category in each of the charts includes children living with relatives, in foster families, in group homes, in institutions, independently, in other settings, and "not reported." It is probable that the percentages of these children who are from single-parent families are at least as high as those referred to juvenile court while still living at home.

If single parenthood is a factor in teen violence, the problem is likely to grow in Tennessee. Tennessee was recently ranked the second worst state in the nation in the percentage of all children who live in single-parent families. The *1994 KIDS COUNT Data Book*, a yearly national study of the well-being of children, said an average of 32.6 percent of Tennessee children - nearly one in three - lived in single-parent families from 1989 through 1993. [12] Only Mississippi had a higher percentage. [13]

Also, the KIDS COUNT report said, Tennessee had the fifth worst growth rate in the nation of percentage of children living in single-parent families. Since 1985, KIDS COUNT reported, the percentage of children living in single-parent families has increased by 33 percent.

An increase in the availability of firearms is another factor in teen violence, the APA report says, adding about 270,000 students carry guns to school each day in the U.S. The National Rifle Association estimates there are about 200 million guns in the hands of private citizens. In a 1993 survey of Tennessee high school students, 18.2 percent of males reported they had carried a gun on one or more of the past 30 days. [14]

Alcohol is another factor in teen violence. "Use of alcohol," the APA report says, "plays a major role in interpersonal violence involving youth ... In about 65 percent of all homicides, perpetrators, victims, or both had been drinking, and alcohol is a factor in at least 55 percent of all fights and assaults in the home." [15]

> **"Violence is woven into the fabric of American society."**
> *Violence & Youth: Psychology's Response*, A report from the American Psychological Association

Other drugs, it says, particularly addictive and expensive drugs such a heroin and cocaine, also contribute to violence because users resort to violent crime to support their habits, and drug marketing is a violent business. [16]

Also, the report says, "The use of alcohol and other drugs by parents has been associated with violent behavior by their children ... Substance-abusing parents are more apt to become physically abusive, sexually abusive, or neglectful in ways that expose their children to risk of abuse by others." [17]

Finally, it must be remembered that teens have not cornered the market on violence. Teen violence is a reflection of our increasingly violent society. "Violence is woven into the fabric of American society," the APA report says. "Though most Americans abhor violence in their communities, homes, and schools, this country has the highest rate of interpersonal violence of any industrialized country ... Our folk heroes and media images - from the cowboy of the old west, to John Wayne, Clint Eastwood, and Arnold Schwarzenegger - often glorify interpersonal violence on an individual and personal level ... Although few Americans would claim to enjoy or encourage violence, many, at the very minimum, passively condone aggression and violence through acceptance of current film and television productions." [18]

State Care, Custody

Too Many Children in State Custody

The Children's Plan is Tennessee's effort to develop a more comprehensive children's services delivery system. In February 1991 the Department of Finance and Administration (F&A) announced the plan and presented general concepts and strategies for implementation. At that time the four primary goals of the Children's Plan were introduced. The exact language of the four goals has been presented slightly differently at various times, but the basic goals are:

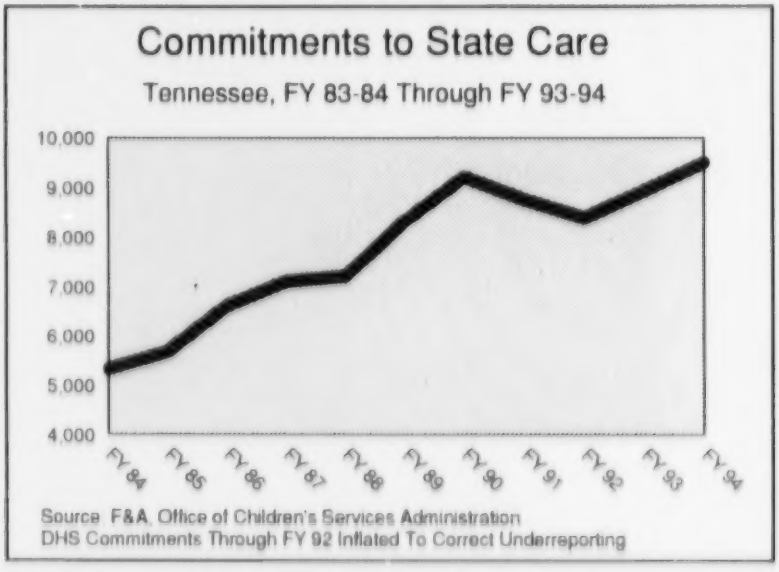
Goal 1: Reduce the number of children in state care.

Goal 2: Provide more appropriate placements and services for children in care.

Goal 3: Improve management of the children's services delivery system.

Goal 4: Maximize the collection of federal and other funding.

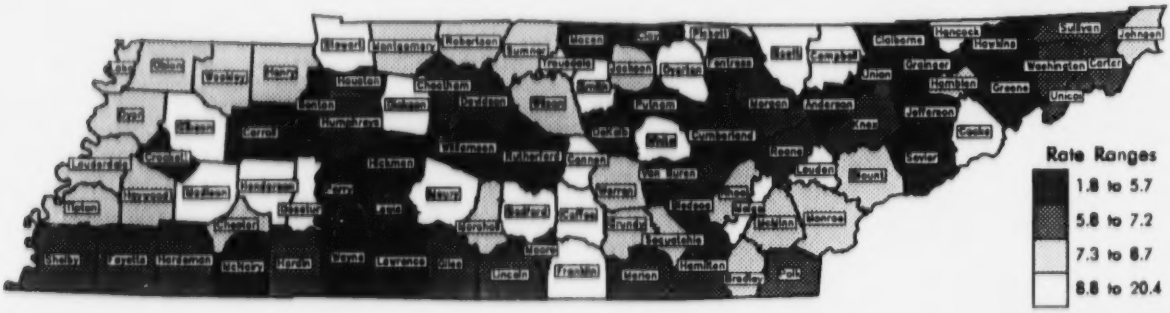
To make comparisons with pre-Children's Plan information as accurate as possible, all state level information presented on children in care in this section includes children placed in psychiatric hospitals under voluntary commitments, Juvenile Court Commitment Orders (JCCOs), and Department of Mental Health and Mental Retardation (MHMR) custody. For FY 92-93 and FY 93-94, statewide information also includes MHMR custody in non-institute placements. This non-institute information was unavailable prior to FY 92-93. Information presented at the county level includes only children in custody. Custody includes departmental custody and Juvenile Court Commitment Orders, but not voluntary commitments.



The Children's Plan was developed partially in response to the continuing rise in new commitments to state care each year. Between FY 83-84 and FY 90-91, new commitments increased by 65 percent. Of greater concern than the increase in new commitments was the alarming increase in the number of children remaining in care at the end of each fiscal year. Unfortunately there is no highly reliable information on the number of children remaining in care before FY 88-89. However, the number remaining in care increased by 21 per-

Commitment Rate of Children to State Custody, FY 93-94

Note: This rate is Per 1,000, NOT percent.



County	Commitments	
	Number	Rate
Anderson	82	5.0
Bedford	82	10.6
Benton	16	4.8
Bledsoe	15	6.3
Blount	154	7.8
Bradley	136	7.5
Campbell	96	10.7
Cannon	27	10.2
Carroll	30	4.6
Carter	79	6.9
Cheatham	54	7.1
Chester	24	8.0
Claiborne	38	5.7
Clay	6	3.6
Cocke	97	13.9
Coffee	125	12.0
Crockett	17	5.2
Cumberland	41	5.0
Davidson	741	6.4
Decatur	28	11.7
DeKalb	9	2.6
Dickson	85	8.9
Dyer	75	8.4
Fayette	46	6.0
Fentress	16	4.2
Franklin	174	20.4
Gibson	104	9.4
Giles	40	6.2
Grainger	13	3.1
Greene	50	3.9
Grundy	29	7.8
Hamblen	93	7.7
Hamilton	457	6.6

County	Commitments	
	Number	Rate
Hancock	24	14.1
Hardeman	41	6.2
Hardin	35	6.2
Hawkins	26	2.5
Haywood	49	8.7
Henderson	61	11.2
Henry	53	8.3
Hickman	21	5.2
Houston	12	7.1
Humphreys	25	6.3
Jackson	17	8.0
Jefferson	34	4.7
Johnson	27	8.5
Knox	507	6.7
Lake	12	7.7
Lauderdale	48	7.5
Lawrence	52	5.6
Lewis	17	6.9
Lincoln	48	6.9
Loudon	87	11.9
McMinn	88	8.5
McNairy	27	4.9
Macon	18	4.5
Madison	249	12.3
Marion	42	6.4
Marshall	44	8.1
Maury	133	9.3
Meigs	19	9.5
Monroe	62	8.0
Montgomery	225	8.4
Moore	7	5.8
Morgan	26	5.8
Obion	64	8.2

County	Commitments	
	Number	Rate
Overton	41	9.7
Perry	3	1.8
Pickett	10	9.0
Polk	20	6.1
Putnam	64	5.7
Rhea	50	8.1
Roane	76	6.8
Robertson	92	8.1
Rutherford	161	5.1
Scott	53	9.8
Sequatchie	20	8.7
Sevier	48	3.9
Shelby	1,565	6.9
Smith	33	9.3
Stewart	28	13.3
Sullivan	202	6.3
Sumner	217	7.6
Tipton	85	7.4
Trousdale	21	14.8
Unicoi	26	7.2
Union	15	4.1
Van Buren	7	5.5
Warren	62	7.5
Washington	141	7.0
Wayne	17	4.8
Weakley	58	8.2
White	44	9.2
Williamson	120	5.1
Wilson	144	7.8

Tennessee	**8,702**	**7.2**

Note: The population ages 1-17 is calculated from 1990 Census data tables provided by the Center for Business and Economic Research, College of Business Administration, The University of Tenessee, Knoxville, 1992.
State fiscal year was from July 1, 1993 through June 30, 1994.

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cent from FY 88-89 to FY 90-91, while commitments over the same period increased by five percent. This indicated that the system was not providing needed permanency for children by returning them to their families, or determining that reunification would not be possible and proceeding with termination of parental rights and placement for adoption. The graph on page 28 shows the number of commitments to state care from FY 83-84 through FY 93-94. The graph on this page shows the number of children committed to care and the number of children remaining in care at the end of the fiscal year for FY 89-90 through FY 93-94.

The number of new commitments to state care has been fairly stable each year since the Children's Plan began in 1991. With the exception of FY 93-94, the number of commitments under the Children's Plan is lower than it was in the year before the plan was announced. There was an eight percent increase in new commitments from FY 90-91 to FY 93-94, due entirely to the FY 93-94 increase. This is important, because many Children's Plan stakeholders had thought that commitments were going up every year under the Children's Plan. This relative stability is also in spite of an increasing number of referrals to juvenile court and an increasing number of violent offenses committed by juveniles.

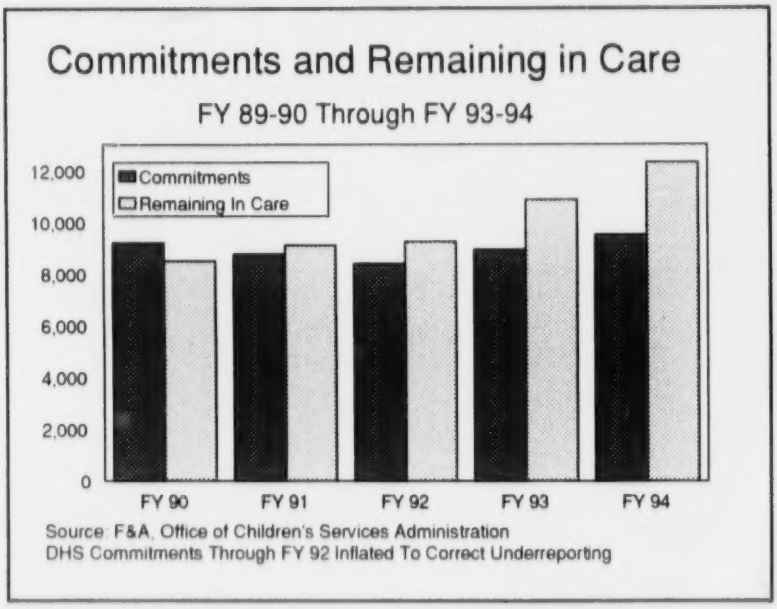
In FY 93-94, there was wide variation in commitment rates to custody across Tennessee's counties. Perry County had the lowest rate, with 1.8 per 1,000 children under 18 years old. Franklin County had the highest rate with 20.4. The state commitment rate was 7.2 per 1,000.

Number of Children Remaining in Care and Custody

The number of children remaining in care and custody has increased at a dramatic rate. There was a 33 percent increase in the number of children in care at the end of June 1994 versus June 30, 1991 (see chart, this page). The trends in commitments and children remaining in care are very similar to the trends seen at the national level.

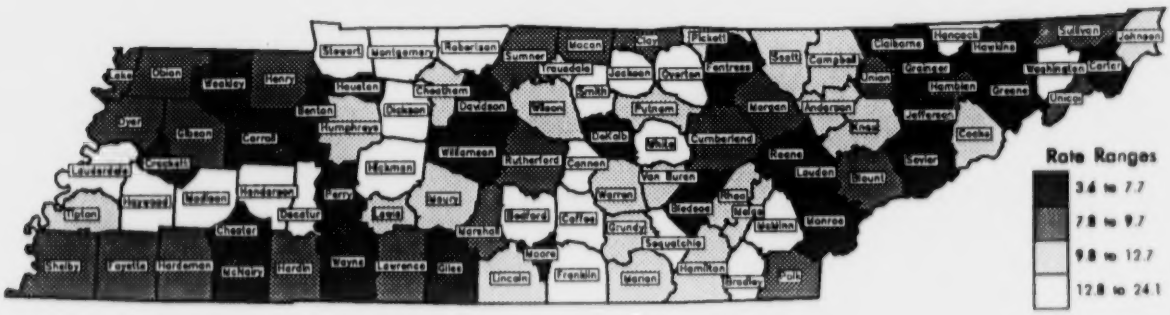
The reason that there are more children in care and custody in Tennessee as well as nationally is mostly due to the fact that there have been more entries than exits. For example, in the period from July 1, 1992 through June 30, 1994 there were 16,928 commitments to custody but only 13,891 exits. Thus there were 3,037 more children committed to custody than removed from it.

There was large variation in rates of children in custody across Tennessee's counties for FY 93-94. The lowest rate was 3.6 per 1,000 children under 18 years old for Grainger County. Hancock County had the highest rate, with 24.1. The state rate of children in custody was 10.0 per 1,000.



Rate of Children Remaining in State Custody, June 30, 1994

Note: This rate is Per 1,000, NOT percent.



County	In State Custody Number	Rate
Anderson	181	11.1
Bedford	142	18.4
Benton	24	7.2
Bledsoe	15	6.3
Blount	177	9.0
Bradley	262	14.4
Campbell	107	11.9
Cannon	56	21.2
Carroll	50	7.7
Carter	83	7.3
Cheatham	95	12.5
Chester	18	6.0
Claiborne	42	6.3
Clay	13	7.8
Cocke	87	12.5
Coffee	149	14.4
Crockett	20	6.1
Cumberland	79	9.7
Davidson	902	7.7
Decatur	41	17.1
DeKalb	22	6.4
Dickson	144	15.0
Dyer	77	8.6
Fayette	60	7.9
Fentress	20	5.2
Franklin	160	18.8
Gibson	105	9.5
Giles	37	5.8
Grainger	15	3.6
Greene	99	7.7
Grundy	37	10.0
Hamblen	112	9.3
Hamilton	776	11.2

County	In State Custody Number	Rate
Hancock	41	24.1
Hardeman	60	9.1
Hardin	52	9.2
Hawkins	74	7.0
Haywood	83	14.7
Henderson	70	12.8
Henry	54	8.5
Hickman	60	14.9
Houston	8	4.7
Humphreys	49	12.3
Jackson	32	15.1
Jefferson	52	7.2
Johnson	35	11.0
Knox	811	10.8
Lake	14	8.9
Lauderdale	96	15.0
Lawrence	86	9.3
Lewis	28	11.3
Lincoln	69	9.9
Loudon	54	7.4
McMinn	148	14.3
McNairy	39	7.1
Macon	34	8.4
Madison	368	18.1
Marion	73	11.2
Marshall	46	8.4
Maury	162	11.3
Meigs	22	11.0
Monroe	47	6.1
Montgomery	352	13.2
Moore	8	6.7
Morgan	40	9.0
Obion	69	8.8

County	In State Custody Number	Rate
Overton	59	13.9
Perry	11	6.6
Pickett	12	10.7
Polk	30	9.1
Putnam	110	9.8
Rhea	74	12.0
Roane	81	7.3
Robertson	189	16.6
Rutherford	254	8.0
Scott	60	11.2
Sequatchie	31	13.6
Sevier	81	6.6
Shelby	1,949	8.6
Smith	47	13.3
Stewart	27	12.8
Sullivan	295	9.1
Sumner	277	9.7
Tipton	129	11.2
Trousdale	18	12.7
Unicoi	34	9.5
Union	30	8.2
Van Buren	15	11.8
Warren	84	10.1
Washington	258	12.8
Wayne	23	6.4
Weakley	51	7.2
White	74	15.4
Williamson	160	6.8
Wilson	234	12.6
Tennessee	**12,140**	**10.0**

Note: The population ages 1-17 is calculated from 1990 Census data tables provided by the Center for Business and Economic Research, College of Business Administration, The University of Tenessee, Knoxville, 1992.

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SUMMARY CHAPTER 1: FAMILY AND COMMUNITIES

Single-Parent Families

- Nearly a third of Tennessee children live in single-parent families.
- The percentage of children living in single-parent families in Tennessee has increased by 33 percent since 1985.
- Nonmarital births in Tennessee have increased from 9.5 percent of all births in 1962 to 32.2 percent in 1991.

Poverty

- More than a fourth of Tennessee children live in poverty.
- Tennessee has the highest per-capita-income growth rate in the nation.
- Forty-three Tennessee counties had per capita incomes below the poverty threshold.

AFDC

- AFDC payments in Tennessee are not enough to bring families out of poverty.
- The maximum AFDC benefit a family of three in Tennessee can receive is $185 per month.
- In 1993, 90.4 percent of AFDC caretakers had three children or fewer.

Nutrition

- Many Tennessee students who are eligible to participate in the free- and reduced-price breakfast program cannot do so because their schools do not offer it.
- Although eligibility requirements are the same for the free- and reduced-price breakfast and lunch programs, less than half of the students participating in the lunch program also participated in the breakfast program.
- In March 1994, 248,916 Tennessee students participated in the lunch program, while 110,959 participated in the breakfast program.

Child Abuse

- About a third of reports of child abuse or neglect are found to be "indicated" each year.
- The number of "indicated" victims of child abuse or neglect has not changed significantly in recent years.
- The vast majority of perpetrators of child abuse in Tennessee are parents or relatives of the victims.

Teen Crime

- The number of referrals to juvenile courts in Tennessee for violent crimes has more than doubled in the past decade.
- Many factors that are strong predictors of violent behavior are known. They include lack of parental supervision, poverty, single parenthood, increased availability of firearms, alcohol and other drugs, and our increasingly violent society.
- In 1992, only 13.7 percent of juveniles referred for murder in Tennessee lived with both parents.

State Care, Custody

- Between FY 1983-84 and FY 1990-91, commitments to state care increased by 65 percent.
- From July 1, 1992 to June 30, 1994, 16,928 children and youth were committed to state care and 13,891 left state care.
- Grainger County had the lowest rate of children in custody at 3.6 per 1,000, and Hancock had the highest rate at 24.1 per 1,000.

Chapter 2
Health

TennCare

Thousands More Children Now Have Health Insurance

TennCare replaces Medicaid and provides health care coverage for persons who were eligible for Medicaid. Additionally, people who are uninsurable and people who were uninsured on or after July 1, 1994 may apply for Medicaid coverage.

TennCare contracts with managed care organizations (MCOs) - private companies which in turn contract with doctors, hospitals, clinics and other health care providers to deliver health care services.

The state is divided into 12 regions, each of which has two or more MCOs from which residents in each region can pick. If a recipient does not pick one, the state assigns an MCO.

Former Gov. Ned McWherter, in a brochure produced by the Tennessee Department of Health, outlined the "beliefs" upon which TennCare is based. They are:

- People should be able to get quality, affordable health care;
- Health care costs can be controlled so Tennesseans won't have to pay more taxes;
- People should be able to work their way off welfare without the fear of losing their health care coverage;
- We should stress preventing health problems, as well as treating them."

The most obvious benefit of TennCare to children is that tens of thousands of them who previously were not covered by health insurance are now insured. As the chart below shows, more than 52,000 children ages birth to 13 who were not eligible to be covered under Medicaid are covered by TennCare. Additionally, nearly than 104,000 girls and women ages 14 to 44 - roughly childbearing age - are now covered and have greater access to prenatal care.

Many of those who are covered by TennCare, but were not covered by Medicaid, are lower-income working people who, because of their limited financial resources, previously had to self-ration health care. This necessarily often meant having little prenatal care and preventative medical care for children and their parents. It also often meant that many typical childhood illnesses, such as ear infections, which are usually easily treated, became quite serious before medical care was sought.

Not only does TennCare make health care available and affordable for many previously uninsured families, it also reduces the stress caused by the ever-looming fear of financial disaster caused by not having medical insurance.

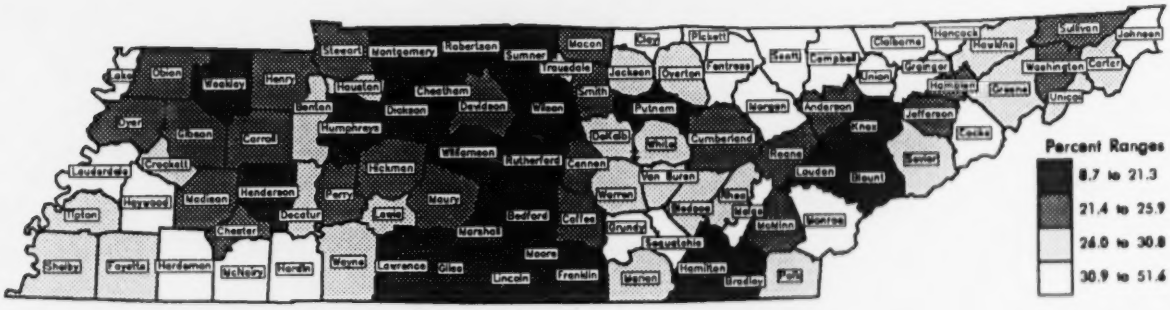
Clearly TennCare is a prescription for healthier children in Tennessee.

TennCare Coverage By Rate Category, 10/24/94

Rate Category	Medicaid Eligibles	Uninsured/ Uninsurable Eligibles
Less than 1 year of age	31,826	1,616
Ages 1 to 13	280,936	50,529
Ages 14 to 44 (male)	53,161	119,861
Ages 14 to 44 (female)	172,075	103,936
Ages 45 to 64	10,711	75,131
Ages 65 and over	4,723	5,340
Medicaid/Medicare Duals	142,231	404
Aid to the blind/disabled	126,350	29,121
Total Enrollees	822,013	385,938

Source: TennCare Bureau

Percent of Total Population Enrolled in TennCare
October 1994



County	TennCare Number	TennCare Percent
Anderson	15,429	22.6
Bedford	6,203	19.6
Benton	3,784	26.2
Bledsoe	3,016	30.7
Blount	16,928	19.0
Bradley	14,537	19.1
Campbell	14,986	42.8
Cannon	2,381	22.4
Carroll	6,147	22.6
Carter	13,628	26.4
Cheatham	5,615	18.7
Chester	2,941	22.8
Claiborne	9,983	37.4
Clay	2,252	31.8
Cocke	11,225	38.4
Coffee	10,434	25.3
Crockett	3,390	26.5
Cumberland	9,461	25.2
Davidson	121,752	23.3
Decatur	2,776	26.9
DeKalb	3,996	27.3
Dickson	7,885	20.9
Dyer	9,087	25.9
Fayette	7,454	29.2
Fentress	6,998	48.0
Franklin	7,130	20.0
Gibson	10,393	23.0
Giles	4,994	19.1
Grainger	5,506	32.0
Greene	14,704	26.2
Grundy	6,058	46.0
Hamblen	12,808	25.1
Hamilton	59,756	21.1

County	TennCare Number	TennCare Percent
Hancock	3,276	49.5
Hardeman	7,936	34.2
Hardin	8,177	35.8
Hawkins	12,270	27.4
Haywood	6,686	35.2
Henderson	4,615	21.0
Henry	6,335	23.1
Hickman	4,290	24.5
Houston	1,926	27.2
Humphreys	3,340	21.3
Jackson	2,805	30.3
Jefferson	8,522	25.4
Johnson	4,733	34.6
Knox	67,007	19.6
Lake	2,430	34.4
Lauderdale	7,939	34.4
Lawrence	7,252	20.2
Lewis	2,616	28.9
Lincoln	5,940	20.5
Loudon	6,850	21.1
McMinn	9,816	23.1
McNairy	6,925	31.0
Macon	4,052	25.2
Madison	19,230	24.2
Marion	7,377	29.5
Marshall	3,860	17.1
Maury	12,087	21.4
Meigs	2,633	32.0
Monroe	10,281	32.9
Montgomery	18,308	16.9
Moore	806	16.9
Morgan	5,543	31.6
Obion	6,747	21.6

County	TennCare Number	TennCare Percent
Overton	5,052	28.7
Perry	1,579	23.3
Pickett	1,658	36.0
Polk	3,692	27.1
Putnam	10,251	19.3
Rhea	7,487	30.8
Roane	11,466	24.7
Robertson	8,198	18.8
Rutherford	17,888	13.2
Scott	9,331	51.6
Sequatchie	2,776	30.9
Sevier	14,528	26.1
Shelby	259,777	30.8
Smith	3,149	22.0
Stewart	2,420	24.5
Sullivan	32,102	22.5
Sumner	16,810	14.8
Tipton	10,720	26.9
Trousdale	1,638	27.5
Unicoi	4,429	26.9
Union	4,611	31.7
Van Buren	1,316	27.3
Warren	8,684	26.3
Washington	20,254	21.7
Wayne	3,901	28.0
Weakley	5,517	17.4
White	5,330	26.2
Williamson	8,112	8.7
Wilson	11,140	15.2

Tennessee	**1,211,464**	**24.2**

Note: Percent is based on the 1994 population estimates made by Department of Sociology, University of Tennessee, Knoxville. The state total includes 1,401out-of-state cases enrolled in TennCare by October 24, 1994.

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Prenatal Care

Some Don't Even Try To Get Adequate Prenatal Care

Prenatal care, and the lack thereof, is an indicator of child well-being because "lack of adequate prenatal care is associated with poor pregnancy outcomes, including high rates of infant and neonatal death, premature birth, birth defects, maternal death, and birth complications." [1]

Not only do women who fail to get adequate prenatal care risk developing easily preventable conditions that put their babies at risk of health problems, such as gestational diabetes, but many of them actively do things that can harm their babies. A recent study of women who failed to get adequate prenatal care during their pregnancies says 75 percent "engaged in behaviors known to be harmful to the fetus." [2]

"Cigarette smoking was the most frequently cited adverse behavior," the study said. Others drank alcohol and took other drugs. Very obese women ignored their prescribed diets.

Given the possible ramifications of failure to get prenatal care and given government efforts during the past two decades to make it affordable and accessible [3], the obvious question is: why did 32.5 percent of Tennessee births lack adequate prenatal care in 1992?

The national study of women who failed to get adequate prenatal care says the women revealed four main reasons: their lifestyles differed from those of mainstream society; they believed prenatal care was important, but stressful events in their lives took priority; they had attempted to get care, but were discouraged, turned away, or given poor information by service delivery personnel; and they did not want their babies. [4]

There are two distinct types of women who fail to get adequate prenatal care, the study says: those who make little or no attempt to get prenatal care; and those who try and fail. [5]

Women who did not seek prenatal care "tended to be single, to have poor support from their mates, but good family support, to be dependent on AFDC, and to have less than a high school education. Most had public or private insurance to cover prenatal care, but they did not take advantage of it. The reasons these women gave for non-use of care were that the baby was unwanted or they had lifestyles in which prenatal care was a low priority." [6]

About 14 percent of those who did not seek prenatal care "had a high level of pregnancy denial." [7] Typically, those in denial claimed not to be aware they were pregnant until they gave birth, or no more than a week before giving birth.

Generalizing about women who do not seek prenatal care at all, the study said their failure to seek care "is a symptom of nonfinancial service system inadequacies, problematic life situations, and serious individual and family dysfunctions." [8]

Saying "the reasons for non-use of prenatal care are diverse and often complex," the study concluded that non-seekers would not have sought prenatal care "even under the best prenatal care system." [9]

Conversely, about half of the women in the study had made "a number" of unsuccessful attempts to obtain prenatal care.

"These women tended to be married, to have good support from their mates and families, to be high school graduates, and to have income from employment." Also, most did not have public or private insurance that would cover prenatal care costs. [10]

One reason cited by them for failure to get prenatal care was inconvenience and expense. Distance to care was the major factor for rural low-income women ..." Lack of child care for women with children was also a problem." [11]

Many of the women did not know where to go for care. Some, although their families had earned income, did not have enough income to pay for prenatal care - typically requiring a down payment of at least $500 - and were incorrectly told they did not qualify for government assistance. Some who tried to apply for government assistance were badly treated by welfare agencies when applying, and gave up.

For many of them, the combined stress of events in their lives, financial worries and unplanned pregnancies was compounded by stress in negotiating the service system.

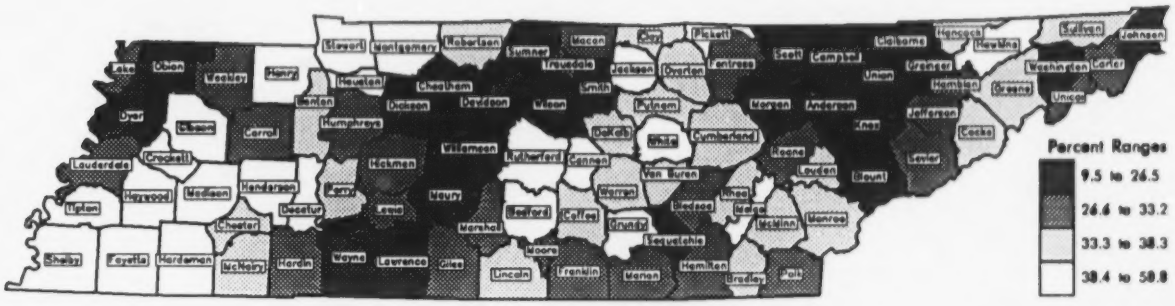
The study concluded by saying that no amount of funding for prenatal care programs will ensure that all or most women will get adequate prenatal care. Women who do not seek prenatal care need post-discharge follow-up from social workers "which may include realistic and timely plans to prevent further pregnancies, adoption or custody counseling, or referral to protective casework services." [12]

It also noted that many of these women, particularly those who were indigent, had previously requested sterilization, but funds and staff were not available. Many were apparently incapable of successfully preventing pregnancy. [13]

For those who seek prenatal care, the study recommends "brief counseling and information and referral during the hospital confinement ... including information on how to gain access to the system if a future pregnancy occurs. Seekers also need ...family-planning information, as well as housing, employment, child care, and budget planning referrals." [14]

Most importantly, the study said, "all no-prenatal-care cases should be flagged for hospital social work department triage." [15]

Percent of Births Lacking Adequate Prenatal Care, 1992



County	Prenatal Care	
	Adequate	Not Adequate
Anderson	78.8	21.2
Bedford	58.7	41.2
Benton	64.2	35.8
Bledsoe	68.9	31.1
Blount	73.7	26.4
Bradley	66.6	33.4
Campbell	75.8	24.3
Cannon	47.5	52.5
Carroll	67.9	32.1
Carter	72.6	27.4
Cheatham	81.0	19.0
Chester	61.7	38.3
Claiborne	73.5	26.5
Clay	64.8	35.2
Cocke	65.9	34.1
Coffee	64.1	35.9
Crockett	60.9	39.0
Cumberland	63.4	36.6
Davidson	79.9	20.1
Decatur	55.2	44.8
DeKalb	66.5	33.5
Dickson	75.0	25.0
Dyer	76.1	24.0
Fayette	59.9	40.1
Fentress	70.9	29.1
Franklin	66.7	33.2
Gibson	55.6	44.3
Giles	72.6	27.4
Grainger	77.8	22.2
Greene	62.9	37.1
Grundy	52.9	47.0
Hamblen	69.8	30.2
Hamilton	70.3	29.7

County	Prenatal Care	
	Adequate	Not Adequate
Hancock	65.4	34.5
Hardeman	52.4	47.6
Hardin	68.0	32.0
Hawkins	60.2	39.8
Haywood	56.7	43.3
Henderson	60.3	39.7
Henry	57.8	42.2
Hickman	69.5	30.5
Houston	41.2	58.8
Humphreys	69.8	30.2
Jackson	52.4	47.7
Jefferson	71.6	28.5
Johnson	75.0	25.0
Knox	79.7	20.3
Lake	68.5	31.4
Lauderdale	68.3	31.7
Lawrence	75.0	25.0
Lewis	68.0	32.0
Lincoln	65.6	34.5
Loudon	66.4	33.6
McMinn	62.2	37.8
McNairy	63.7	36.3
Macon	71.6	28.4
Madison	55.2	44.9
Marion	68.3	31.7
Marshall	69.6	30.4
Maury	74.8	25.2
Meigs	58.7	41.3
Monroe	65.5	34.5
Montgomery	49.0	51.0
Moore	69.2	30.7
Morgan	79.7	20.3
Obion	80.7	19.3

County	Prenatal Care	
	Adequate	Not Adequate
Overton	64.1	35.9
Perry	66.2	33.8
Pickett	60.5	39.6
Polk	69.4	30.7
Putnam	62.7	37.3
Rhea	62.3	37.6
Roane	66.8	33.2
Robertson	66.1	33.9
Rutherford	56.5	43.4
Scott	82.6	17.4
Sequatchie	73.9	26.1
Sevier	67.5	32.5
Shelby	58.6	41.4
Smith	75.0	25.0
Stewart	43.6	56.4
Sullivan	62.4	37.6
Sumner	82.4	17.6
Tipton	55.9	44.1
Trousdale	69.2	30.8
Unicoi	69.0	30.9
Union	74.0	26.1
Van Buren	64.3	35.7
Warren	65.9	34.1
Washington	76.4	23.6
Wayne	81.0	19.0
Weakley	70.8	29.2
White	45.1	54.8
Williamson	90.5	9.5
Wilson	76.3	23.7
Tennessee	**67.5**	**32.5**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

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Low Birth Weight

Low-Birth-Weight Babies Account For Half of Infant Deaths

Low birth weight, being born weighing less than 5.5 pounds, is an indicator of child well-being because "... in the United States, low-birth-weight infants account for two-thirds of the newborn deaths in the first 28 days after birth and half of all deaths during the first year of life. [1] In fact, "...infant mortality is inversely proportional to birth weight..." [2] Moreover, these infants are much more likely to suffer from chronic handicapping conditions, such as cerebral palsy, blindness, mental retardation, and learning disabilities." [3]

The State of Tennessee has set a goal of, by the year 2000, reducing the percentage of low-birth-weight births to no more than 7.1 percent of all births. Unfortunately, Tennessee is moving in the wrong direction to reach this goal.

Both the number and percent of babies born in Tennessee weighing less than 5.5 pounds increased from 1990 to 1992. The percentage increased from 8.2 percent of all births in 1990 to 8.5 percent in 1992. The number of low-birth-weight babies born in Tennessee grew from 6,160 in 1990 to 6,265 in 1992 - an increase of 105.

Although the statewide figures were worse from 1990 to 1992, 41 counties saw improvements. Among the metropolitan counties, only Davidson County improved, going from 787 low-weight births in 1990 to 752 in 1992 - a decrease of 35 low-weight births in two years. Shelby County had the largest numerical increase, going from 1,700 low-weight births in 1990 to 1,752 in 1992. Hamilton County increased by 15 low-weight births, and Knox County increased by 28.

The largest numerical declines from 1990 to 1992, other than in Davidson County, were in Blount and Bradley counties, which both reduced low-weight births by 11; Dyer County, reduced by 15; Franklin, reduced by 17; Gibson County, reduced by 18; Rutherford County, reduced by 18; Smith County, reduced by 15; Trousdale County, reduced by 10; Warren County; reduced by 9; Weakley County, reduced by 18; and Williamson County, reduced by 15.

The biggest numerical increases in low-weight births outside the metropolitan counties from 1990 to 1992 were in: Fayette County, increased by 26; Madison County, increased by 28; Montgomery County, increased by 26; Obion County, increased by 15; and Robertson County, increased by 21.

Recent medical publications indicate all the causes of low birth weight are not yet known. For example, in a report on a study on infant mortality, *The New England Journal of Medicine* asks, "What is the role of stress and psychological factors? Greater advantage needs to be taken of the evolving refinements in psychosocial, physiologic, and biomedical testing in assessing the role of stress, since it may be important ... We need to understand why some pregnant women react to stress in ways that have such profound biologic effects as prematurity and neonatal death." [4]

Some factors common to low-weight births are known. They are: inadequate prenatal care; young teens having babies; poverty, and pregnant women using tobacco and alcohol and other drugs.

Ways to reduce the incidence of low birth weight are also being explored. "Because the factors affecting birth weight are so complex, comprehensive care is required to reduce the rate of low birth weight," the *New England Journal of Medicine*, says. "The interplay of environmental, behavioral, biologic, clinical, and other factors can be systematically addressed only through comprehensive care ... Much of the effort to reduce the rate of low birth weight has been directed toward identification of the risks and intervention during prenatal care. Much more attention needs to be paid to education, preventative medicine, and services before conception. At the same time, it is necessary to promote high-quality prenatal and neonatal care, especially since the latter can compensate for many inadequacies in the quality and distribution of maternal health services ... Benefits could be realized from the application of our present knowledge, however, by the provision of more effective prenatal care, and improved and expanded family-planning services would reduce unwanted and untimely pregnancies, especially among teenagers." [5]

Percent of Low-Birth-Weight Babies, 1992

County	Low-Birth-Weight Babies Number	Percent
Anderson	70	7.6
Bedford	32	7.5
Benton	15	8.7
Bledsoe	5	5.6
Blount	61	5.3
Bradley	58	5.4
Campbell	35	7.6
Cannon	17	10.5
Carroll	26	7.8
Carter	43	7.5
Cheatham	28	6.9
Chester	12	6.6
Claiborne	27	7.6
Clay	2	2.3
Cocke	32	7.8
Coffee	46	7.8
Crockett	15	7.8
Cumberland	33	7.1
Davidson	752	8.9
Decatur	8	6.0
DeKalb	9	5.4
Dickson	48	9.1
Dyer	38	7.4
Fayette	46	11.2
Fentress	11	5.8
Franklin	21	5.1
Gibson	45	7.2
Giles	31	8.9
Grainger	14	6.0
Greene	50	7.8
Grundy	13	7.0
Hamblen	45	6.3
Hamilton	362	9.0

County	Low-Birth-Weight Babies Number	Percent
Hancock	7	8.6
Hardeman	37	8.9
Hardin	20	6.5
Hawkins	45	7.3
Haywood	26	8.9
Henderson	20	7.6
Henry	27	8.0
Hickman	14	5.9
Houston	8	7.8
Humphreys	15	8.2
Jackson	9	8.6
Jefferson	31	7.4
Johnson	14	7.6
Knox	405	8.7
Lake	8	9.0
Lauderdale	34	9.6
Lawrence	37	7.1
Lewis	8	6.4
Lincoln	38	10.1
Loudon	28	7.3
McMinn	43	7.3
McNairy	22	6.4
Macon	14	6.5
Madison	124	9.9
Marion	27	8.4
Marshall	24	7.4
Maury	70	8.9
Meigs	7	7.6
Monroe	30	7.4
Montgomery	176	7.5
Moore	3	5.8
Morgan	14	7.1
Obion	41	9.8

County	Low-Birth-Weight Babies Number	Percent
Overton	9	5.4
Perry	5	7.0
Pickett	4	9.3
Polk	11	6.9
Putnam	47	6.4
Rhea	28	8.4
Roane	34	6.1
Robertson	59	9.7
Rutherford	126	6.2
Scott	16	6.1
Sequatchie	9	8.1
Sevier	58	7.8
Shelby	1,752	11.2
Smith	8	4.7
Stewart	11	8.3
Sullivan	132	7.3
Sumner	91	6.3
Tipton	67	10.5
Trousdale	5	5.5
Unicoi	15	8.6
Union	19	12.7
Van Buren	7	10.0
Warren	32	7.3
Washington	70	6.3
Wayne	14	7.6
Weakley	18	5.5
White	18	7.3
Williamson	50	4.4
Wilson	74	7.6
Tennessee	**6,265**	**8.5**
U.S.A.*		**7.1**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

* U.S. rate is for 1991 and from Kids Count: State Profiles of Child Well-being, The Annie E. Casey Foundation, 1994 Baltimore, MD.

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Infant Mortality

Infant Death Rate Improves, Other Races' Rate Nearly Double White Rate

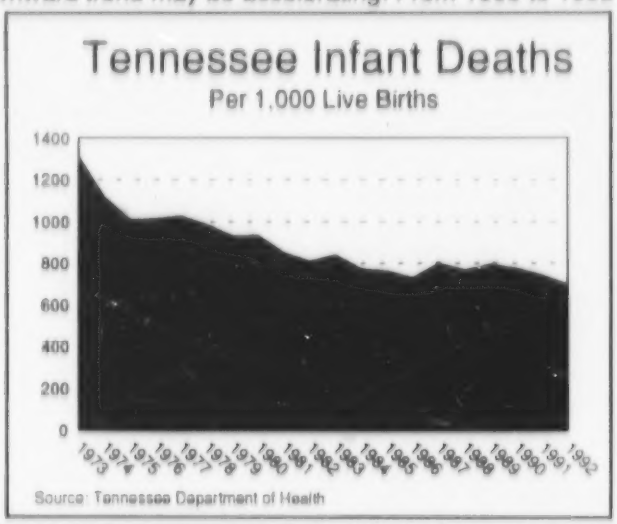
The reason infant mortality - death before a child's first birthday - is indicative of child well-being is obvious. The medical descriptions of the causes are well-documented. In 1992, the five leading causes of infant mortality were birth defects, sudden infant death syndrome, short gestation and low birth weight, respiratory distress syndrome, and infections specific to the perinatal period, according to the Tennessee Department of Health. Precisely what causes these conditions, is less well-known, however.

For example, what causes the second leading cause of infant mortality - sudden infant death syndrome (SIDS) - has not yet been determined. And it may include a significant number of infant murders, said the late Jim Pryor, a prosecutor, expert in child abuse, and member of the Tennessee Commission on Children and Youth.

Tennessee has the lowest infant homicide rate in the U.S., he said, because too few infant homicides are discovered due to inadequate training of some persons who perform autopsies.

A review of general infant mortality data shows Tennessee's infant mortality rate has more or less declined steadily during the past two decades from a rate of 20.3 per 1,000 in 1973 to 9.4 in 1992. In 1973, 1,303 Tennessee infants died. In 1992, 691 died.

The latest figures show the downward trend may be accelerating. From 1990 to 1992 the number of infant deaths in Tennessee decreased by 79 deaths - from 770 in 1990. The rate has declined from 10.3 per 1,000 deaths in 1990 to 9.8 in 1992.



However, when broken down by race, the picture is far less encouraging. While whites in Tennessee had an infant mortality rate of 6.9 per 1,000 live births - compared to a national rate of 8.9 [1] - "other races," which in Tennessee is more than 99 percent African Americans, had an infant mortality rate of 16.9 per 1,000.

The much-higher rate for African Americans "could be due to a number of factors, such as poor maternal health before pregnancy, increased physiologic risks associated with psychosocial risks, poor health habits during pregnancy, insufficient access to health care services, substandard health care (from physicians or other health care personnel), or standard medical care that does not adequately address the needs of pregnant black women." [2]

LEADING CAUSES OF INFANT DEATHS, PER 1,000 LIVE BIRTHS, BY RACE, RESIDENT DATA, TENNESSEE, 1992

	All Races		White		All Other Races	
Cause of Death	Number	Rate	Number	Rate	Number	Rate
All Causes	691	9.4	382	6.9	309	16.9
Birth Defects	158	2.1	102	1.8	56	3.1
Sudden Infant Death Syndrome	133	1.8	88	1.6	45	2.5
Short Gestation and Low Birth Weight	85	1.2	34	0.6	51	2.8
Respiratory Distress Syndrome	45	0.6	30	0.5	15	0.8
Infections Specific to Perinatal Period	22	0.3	11	0.2	11	0.6
Accidents	17	0.2	13	0.2	4	0.2
Birth Complications (placenta, cord, membranes)	13	0.2	7	0.1	6	0.3
Maternal Pregnancy Complications	12	0.2	5	0.1	7	0.4
Pneumonia and Flu	8	0.1	3	0.1	5	0.3
Intrauterine Hypoxia* and Birth Asphyxia	8	0.1	3	0	5	0.3
Septicemia**	4	0.1	1	0	3	0.2
Neonatal Hemorrhage	4	0.1	1	0	3	0.2

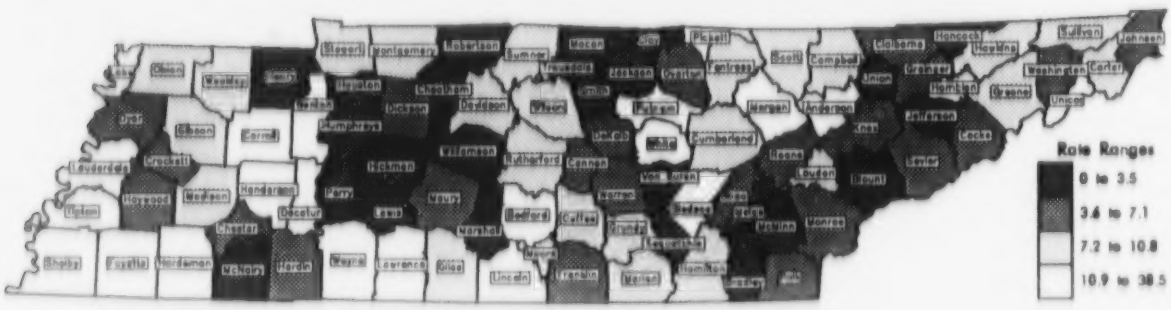
*Oxygen starvation

** Blood poisoning caused by microorganisms

Source: Tennessee Department of Health

Infant Mortality Rate (Per 1,000 Live Births), 1992

Note: This rate is Per 1,000, NOT percent.



County	Infant Mortality Number	Infant Mortality Rate
Anderson	10	10.9
Bedford	8	18.9
Benton	5	28.9
Bledsoe	1	11.1
Blount	4	3.5
Bradley	2	1.9
Campbell	4	8.7
Cannon	1	6.2
Carroll	5	15.0
Carter	5	8.7
Cheatham	1	2.5
Chester	1	5.5
Claiborne	2	5.6
Clay	0	0.0
Cocke	2	4.9
Coffee	5	8.5
Crockett	1	5.2
Cumberland	5	10.8
Davidson	86	10.2
Decatur	2	14.9
DeKalb	1	6.0
Dickson	3	5.7
Dyer	3	5.8
Fayette	6	14.7
Fentress	2	10.6
Franklin	2	4.9
Gibson	6	9.5
Giles	3	8.6
Grainger	1	4.3
Greene	6	9.4
Grundy	2	10.7
Hamblen	9	12.6
Hamilton	34	8.5

County	Infant Mortality Number	Infant Mortality Rate
Hancock	0	0.0
Hardeman	8	19.2
Hardin	2	6.5
Hawkins	5	8.1
Haywood	2	6.9
Henderson	3	11.5
Henry	0	0.0
Hickman	0	0.0
Houston	0	0.0
Humphreys	0	0.0
Jackson	0	0.0
Jefferson	1	2.4
Johnson	1	5.4
Knox	30	6.4
Lake	1	11.2
Lauderdale	4	11.2
Lawrence	6	11.6
Lewis	0	0.0
Lincoln	6	16.0
Loudon	4	10.5
McMinn	1	1.7
McNairy	0	0.0
Macon	0	0.0
Madison	11	8.8
Marion	3	9.3
Marshall	1	3.1
Maury	5	6.3
Meigs	0	0.0
Monroe	2	4.9
Montgomery	21	9.0
Moore	2	38.5
Morgan	4	20.3
Obion	3	7.2

County	Infant Mortality Number	Infant Mortality Rate
Overton	1	6.0
Perry	0	0.0
Pickett	1	23.3
Polk	1	6.3
Putnam	8	10.9
Rhea	2	6.0
Roane	4	7.1
Robertson	2	3.3
Rutherford	16	7.9
Scott	2	7.6
Sequatchie	0	0.0
Sevier	3	4.0
Shelby	223	14.3
Smith	0	0.0
Stewart	1	7.5
Sullivan	18	10.0
Sumner	14	9.6
Tipton	9	14.1
Trousdale	0	0.0
Unicoi	3	17.2
Union	0	0.0
Van Buren	0	0.0
Warren	3	6.9
Washington	6	5.4
Wayne	2	10.9
Weakley	3	9.1
White	3	12.2
Williamson	4	3.5
Wilson	8	8.2
Tennessee	**691**	**9.4**
U.S.A.*		**8.9**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

* U.S. rate is for 1991 and from Kids Count: State Profiles of Child Well-being, The Annie E. Casey Foundation, 1994 Baltimore, MD.

Immunizations

PREVENTABLE DISEASES MAKING COMEBACK

The dramatic decline in the incidence of common childhood diseases has resulted in part from inoculations with highly effective vaccines. The number of reported cases of diphtheria, polio, rubella, and tetanus has declined by 97 percent in the U.S. [1] According to researchers, "the impact of vaccination on the health of the world's peoples is hard to exaggerate. With the exception of safe water, no other modality, not even antibiotics, has had such a major affect on mortality reduction and population growth." [2]

The remarkable decline in the incidence of vaccine-preventable diseases in the U.S. has correlated with approximately 95 percent or more in school-age children who have been immunized prior to school enrollment. These improved immunization rates can be attributed in part to the enactment and enforcement of school immunization laws in each state. [3]

The National Immunization Campaign has helped promote immunizations through coalitions such as the Nashville Immunization Coalition. One focus of the campaign is to provide immunizations at non-traditional sites such as in shopping malls, schools, Head Start centers, and outreach projects.

Despite the existence and availability of these vaccines, as many as 3.5 million children worldwide die each year from diseases that could be prevented. [4]

Failure to immunize young children has resulted in the measles epidemic of 1989 - 1991, and a relative resurgence of mumps since 1986. [9]

Last year, whooping cough - which once killed more American children that all other infectious diseases combined - reached its highest level in 26 years. A 1993 study found that three-fourths of the victims - mostly children aged 2 to 12 - had been fully immunized. The results of the 1993 study conclude that "it is clear that the pertussis vaccine failed to give full protection against the disease." [5] The study's lead researcher called for a nationwide assessment of the vaccine, now administered to millions of infants and preschoolers.

The Centers for Disease Control (CDC) says there is no hard evidence that the pertussis vaccine has "lost its punch" and urges parents to keep immunizing. An epidemiologist with the CDC's National Immunization Program stated that a more likely cause of the increase in whooping cough cases is the "waning immunity among older children who have been vaccinated and the growing number of adults who have never been exposed to the disease and ... may serve as a reservoir." [6] The CDC is considering a strategy to expand immunization guidelines to include vaccination of school-age children and perhaps young adults. [7]

In addition to the year 2000 goal of 90 percent immunization completion rates, the President's Childhood Immunization Initiative establishes coverage goals for individual vaccines. By 1996, 90 percent of two-year-olds should be vaccinated with one dose of measles-mumps-rubella (MMR), three doses of oral polio vaccine (OPV), three or more doses of diphtheria-tetanus-pertussis (DTP) and three doses of haemophilus influenza type b vaccine. The 1996 goal for hepatitis B vaccine is 70 percent.

For children two years old or younger, the immunization rates in some areas are below the national goal of 90 percent for completion of the recommended immunizations by the second birthday. [8]

Suggested Immunization Schedule

AGE	VACCINE RECOMMENDED
2 Months	DTP 1*, Oral Polio 1, HIB 1**, Hepatitis B 1
4 Months	DTP 2, Oral Polio 2, HIB 2, Hepatitis B2
6 Months	DTP 3, HIB 3, Hepatitis B 3
15 Months	MMR 1***, HIB 4, DTP 4, Oral Polio 3
4-6 Years	DTP 5, Oral Polio 4, MMR 2
Every 10 Years	Tetanus and Diphtheria (Td)

* Diphtheria, Tetanus, and pertussis (Whooping Cough)
** HIB Meningitis and other Haemophilus Infections
*** Measles, Mumps, and Rubella

Results from a recent statewide survey of 1,690 children aged two years old conducted by the Tennessee Department of Health (TDH) revealed a 72 percent statewide vaccine completion rate in 1993. This rate was for the basic 4:3:1 series (4 doses of DTP, 3 doses of OPV and 1 dose of MMR). This is a slight increase (1.6 percent) over 1992, but considerably less than the year 2000 goal of 90 percent completion rates. [10]

A critical aspect of the survey of two-year-old children is that it allows the TDH to analyze risk factors associated with incomplete vaccination by two years of age. The risk factors, in order of degree of influence, are: age at first immunization; birth order; mother's age; mother's marital status; race; and mother's education. The order of importance is the same throughout the state although the relative influence of any one factor may differ from region to region, according to the TDH. [11]

The first three factors are the most predictive of incomplete vaccination compared to the other variables: the child's age at first vaccination; the child's birth order; and the age of the mother. The TDH states that these variables can be useful in developing methods to target those children at highest risk of incomplete vaccination. Follow-up efforts can be prioritized by the TDH on the basis of the identified risk factors. [12]

For children of all ages, researchers have cited four reasons for low immunization rates. First, many opportunities to vaccinate children are missed. An example is the failure of providers to administer recommended immunizations during health care visits because they are misinformed about contraindications or because they are unwilling to give more than two vaccines during the same visit. Researchers found frequently missed opportunities to administer the measles-mumps-rubella vaccine were due to ear infections, upper and lower respiratory tract infections, and other minor illnesses that are not contraindications to vaccinations. "Since young children typically have six to eight respiratory tract infections each year, respiratory illnesses, if considered a contraindication, would be a substantial barrier to age-appropriate immunization." [13]

Vaccination Survey Rate of 24-Month-Old Children

REGION	"4:3:1" COMPLETION RATE (%)	
	1992	1993
East 1	71.7	86.6
East 2	68.0	75.7
Central 3	79.7	80.7
Central 4	79.0	83.5
Middle 5	78.4	79.5
Middle 6	76.8	81.1
West 7	94.4	84.3
West 8	80.9	73.2
Memphis-Shelby	56.0	51.3
Nashville-Davidson	66.5	72.8
Knoxville-Knox	68.7	72.9
Chattanooga-Hamilton	68.7	72.7
Jackson-Madison	78.7	82.7
Sullivan	80.0	74.4
Tennessee (weighted)	70.4	72.0

Source: Tennessee Department of Health, 1993. See list of regions in appendix.

The second reason for low immunization rates nationwide is that the deficiencies in the health care delivery system in the public sector have limited the administration of vaccines. Some of these deficiencies include insufficient clinical staff and policies that serve as barriers. The third and fourth reasons for low immunization rates are inadequate access to medical care and lack of public awareness in some communities, which result in a lack of demand for immunization services. [14]

To improve immunization rates, there must be increased awareness of the necessity for age-appropriate inoculations and understanding that minor illnesses should not be considered contraindications to vaccination. Access to immunizations is essential to reach the 90 percent immunization rates by the year 2000. The National Immunization Campaign has shown promise in promoting communities to administer immunizations at non-traditional sites to provide better service delivery for parents and their children.

REPORTED CASES OF VACCINE-PREVENTABLE CHILDHOOD DISEASES IN THE U.S.

DISEASE	MAXIMUM NUMBER OF CASES AND YEAR	CASES IN 1991	PERCENT CHANGE
Diphtheria	206,939 - 1921	2	-99.9%
Measles	894,134 - 1941	9,488	-98.9%
Mumps*	152,209 - 1968	4,031	-97.4%
Pertussis (Whooping Cough)	265,269 - 1934	2,575	-99.0%
Polio (paralytic)	21,269 - 1952	0***	-100.0%
Rubella**	57,686 - 1969	1,372	-97.6%
Congenital Rubella Syndrome	20,000 - 1964-1965	36	-99.8%
Tetanus	1,560*** - 1923	49	-96.9%

* Mumps became a reportable disease in 1968

** Rubella became a reportable disease in 1966.

*** Vaccine causes 5 to 10 cases annually.

Source: New England Journal of Medicine, December 17, 1992, p. 1,794.

Child Deaths

Tennessee Child Death Rate Improving

The good news about Tennessee's child death rate is that it is improving. The Tennessee death rate among children ages 1 through 14 years old in 1980 was 44 per 100,000. In 1990, it had declined to 35 per 100,000. In 1992, the rate was 31.9 per 100,000. In 1990, 333 Tennessee children died, compared to 306 in 1992 - an 8.1 percent reduction.

The bad news is that Tennessee still ranks 39th in the nation in child deaths. The national rate, averaged from 1985 through 1991, was 30.7 per 100,000.

There are many causes of child death in Tennessee, but accidents are the primary killer of children. As the charts below indicate, about 41.5 percent of Tennessee's child deaths were caused by accidents in 1992 - 127 of 306 deaths. The greatest decline in child deaths from 1990 to 1992 was in non-vehicular accidents. In 1990, 51 children ages 1-4 died in non-vehicular accidents, compared to 29 in 1992. In 1990, 42 deaths of children ages 5 to 14 were attributed to non-vehicular accidents, compared to 32 in 1992.

More than a third - about 36 percent - of accidental child deaths in Tennessee - 20 for 1- to 4-year-olds and 46 for 5- to 14-year-olds - were caused by vehicle accidents in 1992. In 1990, about 47 percent of accidental deaths were vehicle deaths.

The reduction in child deaths - particularly for young children - is partially attributable to Tennessee's 1977 child restraint device law, which requires each child less than four years old to be in a child passenger restraint device when in a moving vehicle. Motor vehicle accidents took 29 lives of 1- to four-year-olds in 1990, and 20 in 1992. Only four of the 15 children in the 0- to-three-year-old age group who were killed in vehicle crashes in 1992 were in proper child restraint devices. [1]

The number of tickets handed out by the Tennessee Highway Patrol for violation of the child restraint law decreased from 7,590 in fiscal year 1990-91 to 6,585 in fiscal year 1992-93, indicating compliance may be increasing. The Tennessee Department of Safety estimated compliance with the child restraint law to be about 40 percent in 1990 - up from about 9 percent in 1977.

Compliance with the law and the effectiveness of safety seats may be increasing because of traffic judges who are increasingly sentencing violators to training classes in which offenders learn how risky it is not to use vehicle child restraints and in which they learn how to properly use them.

Vehicles are also dangerous to children on foot. In 1992, 13 pedestrians ages birth to 15 were killed by vehicles. [2]

Child Death Rate Per 100,000 By Leading Causes, Ages 1-4, 1992

CAUSES	NUMBER OF DEATHS	RATE
Accidents	49	18.0
Motor Vehicle Accidents	20	7.3
(Included in "ACCIDENTS", above)		
Birth Defects	16	5.9
Cancer	13	4.8
Homicide	10	3.7
Two Or More Causes Tied	4	1.5

Source: Tennessee Department of Health

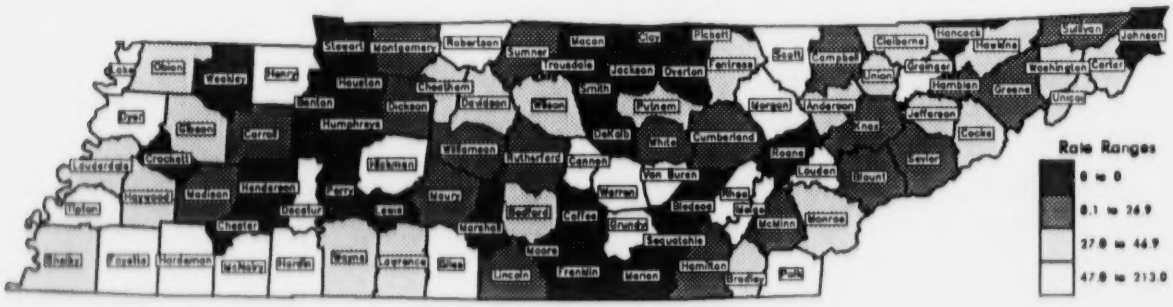
Child Death Rate Per 100,000 By Leading Causes, Ages 5-14, 1992

CAUSES	NUMBER OF DEATHS	RATE
Accidents	78	11.3
Motor Vehicle Accidents	46	6.7
(Included in "ACCIDENTS", above)		
Cancer	24	3.5
Birth Defects	10	1.5
Heart Disease	4	0.6
Two Or More Causes Tied	4	0.6

Source: Tennessee Department of Health

Child Death Rate Per 100,000 Children Ages 1-14, 1992

Note: This rate is Per 100,000, NOT percent.



County	Child Deaths	
	Number	Rate
Anderson	4	31.3
Bedford	2	32.7
Benton	0	0.0
Bledsoe	0	0.0
Blount	4	25.9
Bradley	4	28.3
Campbell	1	14.9
Cannon	1	47.8
Carroll	1	19.8
Carter	4	46.8
Cheatham	3	46.9
Chester	0	0.0
Claiborne	2	39.6
Clay	0	0.0
Cocke	2	37.9
Coffee	0	0.0
Crockett	0	0.0
Cumberland	1	15.8
Davidson	32	34.1
Decatur	1	55.6
DeKalb	0	0.0
Dickson	2	25.3
Dyer	4	56.8
Fayette	3	51.7
Fentress	1	35.0
Franklin	0	0.0
Gibson	3	35.1
Giles	3	60.0
Grainger	2	63.0
Greene	1	10.3
Grundy	2	72.2
Hamblen	2	21.7
Hamilton	14	26.3

County	Child Deaths	
	Number	Rate
Hancock	0	0.0
Hardeman	3	58.0
Hardin	3	68.6
Hawkins	3	37.4
Haywood	2	45.9
Henderson	0	0.0
Henry	5	102.9
Hickman	4	126.5
Houston	0	0.0
Humphreys	0	0.0
Jackson	0	0.0
Jefferson	2	36.9
Johnson	0	0.0
Knox	15	25.2
Lake	1	87.9
Lauderdale	2	39.4
Lawrence	3	41.3
Lewis	0	0.0
Lincoln	1	17.9
Loudon	4	70.3
McMinn	1	12.6
McNairy	9	213.0
Macon	0	0.0
Madison	4	24.5
Marion	0	0.0
Marshall	0	0.0
Maury	3	25.8
Meigs	1	66.0
Monroe	2	33.9
Montgomery	3	13.8
Moore	0	0.0
Morgan	2	59.6
Obion	2	34.3

County	Child Deaths	
	Number	Rate
Overton	0	0.0
Perry	0	0.0
Pickett	0	0.0
Polk	2	84.5
Putnam	3	33.3
Rhea	3	64.8
Roane	0	0.0
Robertson	5	53.6
Rutherford	6	22.1
Scott	2	49.2
Sequatchie	0	0.0
Sevier	2	20.4
Shelby	70	38.6
Smith	0	0.0
Stewart	0	0.0
Sullivan	6	24.7
Sumner	6	26.2
Tipton	5	53.3
Trousdale	0	0.0
Unicoi	1	37.7
Union	1	34.3
Van Buren	1	104.5
Warren	4	62.4
Washington	5	32.2
Wayne	1	36.6
Weakley	0	0.0
White	1	26.9
Williamson	3	15.1
Wilson	5	32.7

Tennessee	**306**	**31.9**
U.S.A.*		**30.7**

Source: Office of Health Statistics and Information, Tennessee Department of Health.
Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville. * U.S. rate is for 1991 and from Kids Count: State Profiles of Child Well-being, The Annie E. Casey Foundation, 1994, Baltimore, MD.

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Teen Pregnancy

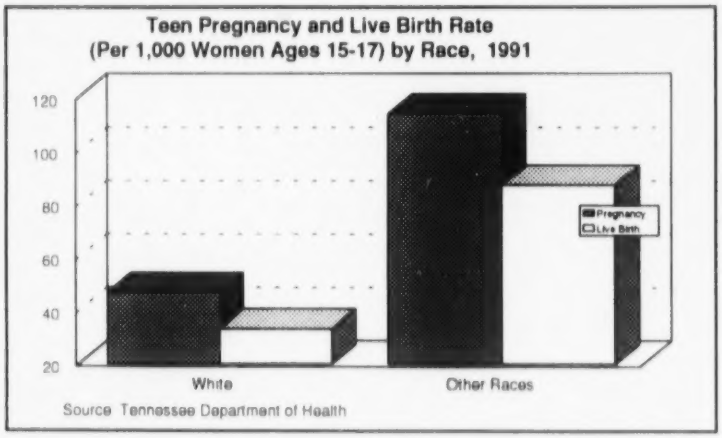
Tennessee Teen Pregnancy Rate Improves

Tennessee's 1992 adolescent pregnancy rate dropped to a level not reported since the mid-1980s. The pregnancy rate for 10-17 year olds decreased seven percent to 23.8 pregnancies per 1,000 females, down from 25.6 in 1991. Decreases occurred in rates for both white and non-white females from 1991 to 1992. The white rate declined 7.9 percent from 19.1 to 17.6. The non-white rate declined from 48.9 to 45.9, a decrease of 6.1 percent. While the pregnancy rate for 10-14 year olds remained stable at 3.2, the rates for 15-17 year olds decreased from 60.9 to 56.5. The most dramatic decrease occurred in the white 15-17 age group, which decreased from 46.5 to 42.8 - an 8 percent decrease.

One factor in the reduction of the teen pregnancy rate may be the advent of the state's Adolescent Pregnancy Initiative. The initiative focuses on three areas: preventing teen pregnancies; increasing community involvement and awareness of the problems of teen pregnancy; and improving teen pregnancy outcomes and parenting classes. Another factor may be the statutory requirement since the 1991-92 academic year that family life education be taught in Tennessee schools. The state family life curriculum stresses responsibility and family relationships, focuses on abstinence, and may include sex education.

Another factor may be local teen pregnancy prevention programs which are at least partially funded by state grants.

Among the reasons teen pregnancy is discouraged is early childbearing results in negative medical consequences for mother and child. The worst physical effects of childbirth are suffered by mothers under the age of 15 who have greater risks of complications and mortality. Teen mothers under the age of 18 are also "more likely to have toxemia, anemia, and prolonged labor. Their babies are at higher risk of prematurity and low birth weight." [1]



Teens begin their pregnancies with many preexisting conditions, such as alcohol use, substance abuse, poor nutrition, sexually transmitted diseases, and anemia, that can produce negative outcomes. The consequences "stem from the problem behavior or illness, not from the mere fact of age at conception." [2]

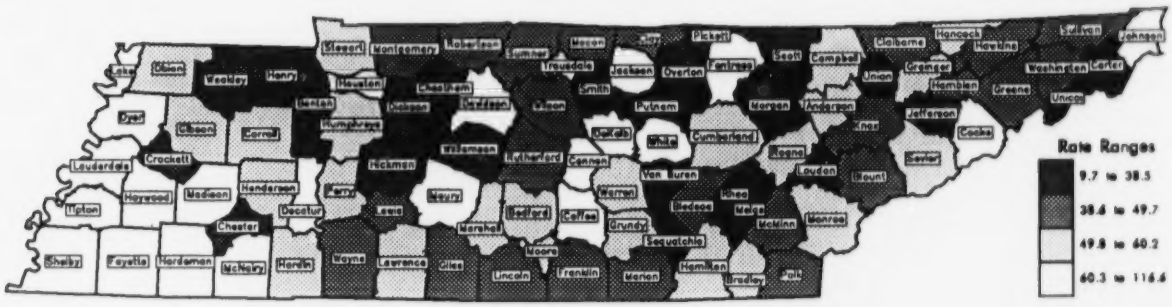
Compared to young women who delay childbearing until their twenties, teen mothers are generally socially disadvantaged. Teen mothers have reduced educational attainment, "unstable marriages and high divorce rates, or no marriage, more subsequent births closer together and unintended, lower status jobs, lower incomes, and in some cases, long-term welfare dependency. Adverse effects on children of teen parents include lower achievement, many more behavioral and emotional problems, high risk of becoming teen parents themselves, and a lifetime of poverty." [3]

In addition to the personal costs, the societal costs of teen pregnancy are tremendous. Public costs related to teen childbearing totaled $120.3 billion in Aid to Families with Dependent Children (AFDC), Medicaid, and Food Stamps from 1985 through 1990. If each birth had been postponed until the mother was at least 20, an estimated $48.1 billion could have been saved, according to a report by the U.S. General Accounting Office. [4]

continued

Teen Pregnancy Rate (Per 1,000 Women Ages 15-17), 1992

Note: This rate is Per 1,000, NOT percent.



County	Teen Pregnancy Number	Rate
Anderson	75	55.6
Bedford	37	55.9
Benton	10	32.9
Bledsoe	9	49.2
Blount	82	46.4
Bradley	90	53.2
Campbell	41	49.8
Cannon	17	82.1
Carroll	31	56.7
Carter	36	32.5
Cheatham	22	36.6
Chester	11	31.1
Claiborne	28	43.7
Clay	6	40.0
Cocke	39	62.2
Coffee	54	61.4
Crockett	8	30.5
Cumberland	38	52.3
Davidson	692	69.8
Decatur	13	65.7
DeKalb	19	64.2
Dickson	26	32.0
Dyer	47	61.2
Fayette	51	89.3
Fentress	22	63.8
Franklin	37	45.3
Gibson	52	55.1
Giles	23	39.2
Grainger	21	60.2
Greene	55	48.0
Grundy	18	54.1
Hamblen	52	47.3
Hamilton	333	57.0

County	Teen Pregnancy Number	Rate
Hancock	7	51.1
Hardeman	61	116.6
Hardin	27	55.7
Hawkins	39	40.7
Haywood	38	88.6
Henderson	26	57.3
Henry	19	37.0
Hickman	13	37.9
Houston	10	63.7
Humphreys	16	50.8
Jackson	15	86.2
Jefferson	27	33.4
Johnson	21	75.8
Knox	312	44.0
Lake	12	90.9
Lauderdale	40	77.5
Lawrence	40	51.9
Lewis	10	49.3
Lincoln	27	44.0
Loudon	24	38.5
McMinn	43	47.1
McNairy	36	79.3
Macon	16	49.7
Madison	116	65.2
Marion	25	43.5
Marshall	25	53.0
Maury	74	67.3
Meigs	4	23.5
Monroe	41	54.7
Montgomery	95	43.4
Moore	6	54.5
Morgan	13	33.7
Obion	41	59.4

County	Teen Pregnancy Number	Rate
Overton	11	29.7
Perry	8	59.3
Pickett	2	23.0
Polk	13	40.9
Putnam	44	33.7
Rhea	17	28.7
Roane	50	51.2
Robertson	34	39.4
Rutherford	122	39.2
Scott	15	35.8
Sequatchie	6	30.9
Sevier	56	51.2
Shelby	1,506	83.1
Smith	7	24.1
Stewart	10	50.8
Sullivan	117	40.9
Sumner	111	45.6
Tipton	60	69.5
Trousdale	10	87.0
Unicoi	13	36.4
Union	9	29.0
Van Buren	1	9.7
Warren	42	59.3
Washington	79	38.6
Wayne	14	46.2
Weakley	20	21.7
White	26	68.1
Williamson	68	34.6
Wilson	66	44.4
Tennessee	**5,951**	**56.5**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

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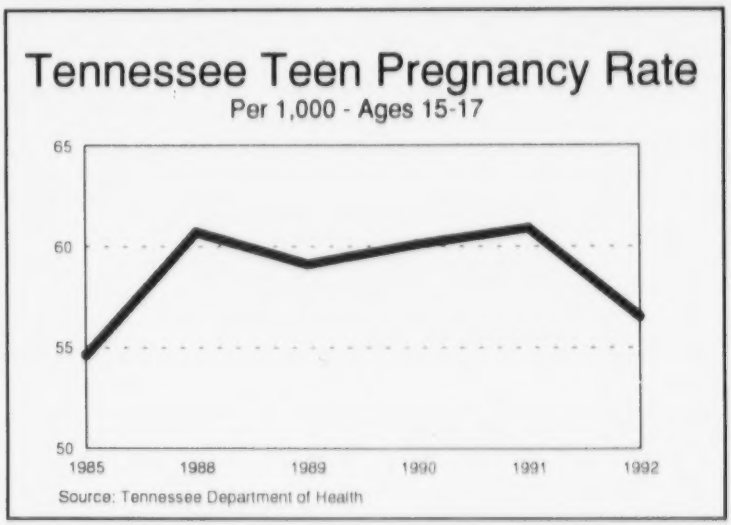
What are the facts about teen pregnancy and teen births?

Not all sexually active teens are at equal risk of negative outcomes from their behavior. Young women who engage in sexual intercourse at an early age have a higher risk of unintended pregnancy, primarily because they are not using contraception. According to a 1979 Johns Hopkins Survey, only 31 percent of girls who had sex before they were 15 used any form of contraception. In contrast, for those who had first sex between 15 and 17 years, 52 percent used contraception. Older teens in stable relationships appeared to be able to use effective contraception. [5]



In Tennessee, 36.2 percent of teens in grades 9-12 had sexual intercourse before the age of 15, according to their responses to the 1993 Youth Risk Behavior Survey (YRBS). The YRBS solicited responses from 38 randomly selected Tennessee public schools in the self-reported survey of 3,691 students administered by the Tennessee Department of Health in conjunction with the Tennessee Department of Education.

Teens are having unprotected sex. The YRBS results showed that among 12th graders who were sexually active, 10.7 percent used no method of contraception. Unprotected sex is a greater risk for African-American teens than white, according to the YRBS results. Overall, twice as many African-American teens (17.2 percent) reported having unprotected sex compared to white teens (8.9 percent). The results of unprotected sex is apparent in teen pregnancy statistics. In Tennessee during 1991, 6,433 girls ages 15-17 became pregnant for a rate of 60.9 per 1,000 - slightly less than the 1990 teen pregnancy rate of 63.4.

In Tennessee, a greater percentage of all births are to single teens compared to the rest of the U.S. During 1991, 11.3 percent of all births in Tennessee were to single teens - nine percent is the U.S. average. [6] For all girls in Tennessee aged 15-17, both married and single, 4,703 gave birth for a rate of 44.5 per 1,000.

Approximately 41 percent of teen pregnancies result in abortion in the U.S. [7] Only 26 percent of teen pregnancies ended in abortions in Tennessee during 1991: there were 1,686 induced terminations for girls aged 15-17 and a total of 44 fetal deaths.

Girls who are achievers (e.g. who are doing well in school and expect to go to college), when confronted with teen pregnancy, obtain abortions, according to findings from the National Longitudinal Survey of Youth. [8] Girls with low basic skill mastery from families living in poverty are five to seven times more likely to become mothers during their teen years than girls with average or better basic skills mastery and not from families in poverty. Research has shown that differences among whites, African Americans, and Hispanics were insignificant. It provides "strong confirmation for the 'underclass' theory - that increasing numbers of young people in the United States are falling behind and being cast in roles that will prevent them from ever catching up and making it. Although race is a factor, poor achieving white youngsters have low odds for success as well." [9]

Young women who become teen parents are those who "enter into sexual relationships at very early ages and use no contraception. They are low achievers in school, have poor prospects, and low expectations for the future. Girls who become teen mothers often have friends whose attitudes are accepting of early parenthood. Teen mothers come from poor families, frequently single-headed (mother) households, with low educational levels, and often their mothers were teen mothers as well as their older sisters. Girls who become teen mothers do not have parents who support or monitor them. Their homes are located in poverty areas ... with high unemployment rates." [10]

What do young people think about teen parenthood?

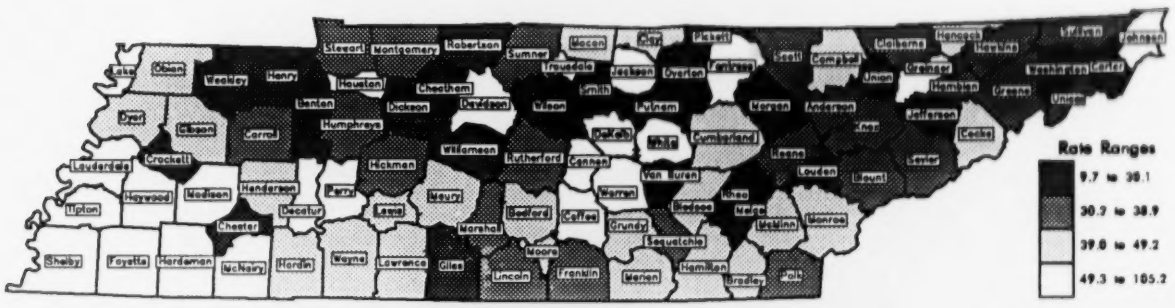
Most young people view teen parenthood negatively. In the 1987 National Survey of Children, four out of five youths aged 18-22 agreed that becoming a teen parent is one of the worst things that could happen to a 16-year-old girl or boy. [11]

For young teens who become parents, few want to be. Eighty-four percent of teen pregnancies for girls aged 17 and younger were unintended, according to the national survey. The pregnancies occurred sooner than desired or were not wanted at any time. [12] This is considerably more than older teens aged 18-19: approximately two thirds of births to older teens were described by the teen as having been wanted, according to the 1988 National Survey of Families and Households. [13]

Because adolescents are still in the process of forming their identities, establishing their self-confidence, and "learning how to manage relationships and intimacy, sexual activity before a young person is emotionally mature can be a painful and psychologically damaging experience." [14]

Teen Live Birth Rate (Per 1,000 Women Ages 15-17), 1992

Note: This rate is Per 1,000, NOT percent.



County	Live Birth	
	Number	Rate
Anderson	51	37.8
Bedford	27	40.8
Benton	9	29.6
Bledsoe	9	49.2
Blount	68	38.5
Bradley	73	43.2
Campbell	38	46.2
Cannon	16	77.3
Carroll	20	36.6
Carter	27	24.4
Cheatham	17	28.3
Chester	8	22.6
Claiborne	20	31.2
Clay	6	40.0
Cocke	29	46.3
Coffee	44	50.1
Crockett	6	22.9
Cumberland	31	42.6
Davidson	494	49.8
Decatur	12	60.6
DeKalb	18	60.8
Dickson	23	28.3
Dyer	33	43.0
Fayette	41	71.8
Fentress	17	49.3
Franklin	28	34.3
Gibson	37	39.2
Giles	16	27.3
Grainger	21	60.2
Greene	39	34.1
Grundy	16	48.0
Hamblen	41	37.3
Hamilton	260	44.5

County	Live Birth	
	Number	Rate
Hancock	6	43.8
Hardeman	55	105.2
Hardin	21	43.3
Hawkins	34	35.5
Haywood	30	69.9
Henderson	19	41.9
Henry	15	29.2
Hickman	12	35.0
Houston	9	57.3
Humphreys	12	38.1
Jackson	12	69.0
Jefferson	19	23.5
Johnson	19	68.6
Knox	217	30.6
Lake	11	83.3
Lauderdale	35	67.8
Lawrence	33	42.9
Lewis	9	44.3
Lincoln	20	32.6
Loudon	16	25.6
McMinn	38	41.6
McNairy	29	63.9
Macon	15	46.6
Madison	94	52.9
Marion	23	40.0
Marshall	18	38.1
Maury	51	46.4
Meigs	4	23.5
Monroe	30	40.0
Montgomery	72	32.9
Moore	5	45.5
Morgan	10	25.9
Obion	32	46.4

County	Live Birth	
	Number	Rate
Overton	10	27.0
Perry	7	51.9
Pickett	2	23.0
Polk	12	37.7
Putnam	33	25.3
Rhea	14	23.6
Roane	38	38.9
Robertson	26	30.1
Rutherford	96	30.8
Scott	15	35.8
Sequatchie	6	30.9
Sevier	39	35.7
Shelby	1,046	57.7
Smith	5	17.2
Stewart	7	35.5
Sullivan	99	34.6
Sumner	78	32.1
Tipton	50	57.9
Trousdale	7	60.9
Unicoi	12	33.6
Union	9	29.0
Van Buren	1	9.7
Warren	37	52.3
Washington	59	28.8
Wayne	13	42.9
Weakley	14	15.2
White	21	55.0
Williamson	44	22.4
Wilson	37	24.9

Tennessee	**4,457**	**42.3**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

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Drug Abuse

Is Teen Substance Abuse Growing?

Good data on drug abuse are difficult to gather. Some drug abuse data are gathered from self-reports, which may be neither objective nor reliable.

There are two sources of data regarding drug abuse among teens in Tennessee. One, the 1993 Youth Risk Behavior Survey [1] is a weighted survey of Tennessee high school students that relies on self-reporting. The other is records of referrals to juvenile courts.

These sources indicate that alcohol is overwhelmingly the drug of choice among Tennessee teens. Marijuana ran a distant second, and, perhaps surprisingly, cocaine and its various derivatives apparently ran a distant third.

A review of records compiled by the Tennessee Council of Juvenile and Family Court Judges shows 3,549 referrals were made to juvenile courts for alcohol possession, drinking or drunkenness in 1992. During the same year, 613 referrals were made for possession or sale of marijuana, and 599 referrals were made for possession of controlled substances.

The 1993 Youth Risk Behavior Survey shows that 76.8 percent of Tennessee high school students have taken at least one drink of alcohol, 32.5 percent have smoked marijuana, and 5.1 percent have taken some form of cocaine.

All of these figures are lower than reported in 1990, the first year the survey was conducted. The 1990 Youth Risk Behavior Survey showed that 83 percent of Tennessee high school students had taken at least one drink of alcohol, 35.3 percent had smoked marijuana, and 7.1 percent had taken some form of cocaine.

During the 30-day period before the 1993 survey, 42.6 percent had consumed alcohol, 16.5 percent had smoked marijuana, and two percent had taken cocaine in some form.

A comparison with results of the 1990 survey shows reductions in the percentages who had recently consumed alcohol and those who had recently taken cocaine, and a small increase in the percentage who had recently smoked marijuana. During the 30-day period before the 1990 survey, 50.3 percent had consumed alcohol, 15.5 percent had smoked marijuana, and 2.2 percent had taken cocaine in some form.

Other drugs were addressed in the surveys in only one question, which in 1993 asked if students had ever "used any other type of illegal drug, such as LSD, PCP, ecstasy, mushrooms, speed, ice, heroin or pills." In 1993, nearly a fifth - 19.5 percent - answered that they had. In 1990 15.2 percent answered affirmatively to a similarly worded question.

A recent Memphis juvenile court study indicates cocaine may be a larger problem in urban areas than the statewide risk behavior study shows.

The 1993 Memphis study involved indiscriminate drug testing of juveniles ages 14-17 who were brought to the Memphis juvenile court's detention center by law enforcement personnel. In his memo accompanying the study, Judge Kenneth A. Turner, Judge of the Juvenile Court of Memphis and Shelby County, writes, "Five percent of detainees were found to be using cocaine ... and 27 percent were using marijuana ... Juvenile Court arrest statistics, however, reveal far more arrests for cocaine than marijuana trafficking. In 1992 only 122 juveniles were arrested on marijuana charges, whereas 496 were arrested on cocaine charges."

As to whether substance abuse has increased among Tennessee teens, juvenile court data show significant increases in referrals related to alcohol, marijuana and controlled substances (see chart below). However, reporting difficulties and changes in methods of reporting and compiling data over the years may partially account for increases or decreases in referrals in each offense category.

The data also show reductions in some referral categories. Comparing 1984 referral data to 1992 data, reductions occur in sale of controlled substances and driving under the influence. The reduction in DUI referrals may reflect the nation's changing attitudes toward drunken driving. A comparison of 1987 referral data and 1992 data shows a significant reduction in possession or sale of marijuana referrals and only a slight increase in alcohol possession, drinking and drunkenness referrals.

Juvenile Court Referrals For Alcohol/Other Drug Offenses
Tennessee 1984, 1987, 1991, 1992

Offense	1984	1987	1991	1992
Alcohol possession, drinking, drunkenness	2436	3489	3535	3549
Sale of controlled substances	832	194	707	508
Possession or sale of marijuana	79	1105	438	613
Possession of controlled substances	184	333	367	599
Driving under the influence	441	530	252	272

Source: Tennessee Council of Juvenile and Family Court Judges

HIV/AIDS

Many Teens May Be Infected and Not Know It

AIDS, acquired immune deficiency syndrome, is a result of infection with the human immunodeficiency virus or HIV. HIV attacks and destroys the immune system, leaving the body unable to fight sickness and disease. To date, there is no known cure for the disease.

Many teens may be infected with the HIV virus and not know it. Many people in their twenties who have the disease now are likely to have been infected as teenagers. [1]

The HIV virus lives in blood, semen, and vaginal secretions and is spread by having sex with an infected partner; sharing needles with an infected person; from an infected pregnant woman to her baby; or blood transfusions and blood-clotting products.

For each person reported with AIDS, there are others infected with HIV who have not yet developed a diagnosed AIDS-related condition. Many people with HIV go untested for the virus since the early symptoms of the infection are rare and, when present, often go unrecognized due to a lack of knowledge regarding risk behaviors, and due to a lack of access to services. [2]

AIDS is spreading more rapidly among young adults in Tennessee than across the nation as a whole. State records show 25 percent (886 cases) of the cumulative reports of persons with AIDS in Tennessee (3,487 cases) were aged 20-29 at the time of their diagnosis. The national average is 19 percent. It is likely that many of these young adults became infected with HIV as teens since it takes seven to ten years for someone infected with HIV to develop an AIDS-related condition.

Females now account for a greater proportion of all AIDS cases reported in Tennessee than in the past. In 1985, the number of new AIDS cases for females (two cases) represented approximately three percent of the total 79 new cases diagnosed that year. By 1992, "the 79 new cases among women represented 11 percent of the year's 723 cases. In Tennessee, the 276 adolescent and adult women represent approximately eight percent of all AIDS cases (3,487) reported through October 1993. Nationally, women represent approximately 12 percent of all AIDS cases reported (40,702 of 339,250) through September, 1993." [3]

For childbearing women and newborns in Tennessee, HIV infection is a significant problem, according to the findings of an ongoing statewide survey. If the mother is infected, the newborn will acquire antibodies indicating the presence of the virus. The infant may or may not develop the virus; about 30 percent of infants born to infected mothers develop AIDS. [4] A recent national study has shown AZT treatments to HIV-infected pregnant women seriously reduced the percentage of babies born with HIV. [5]

Among African-American childbearing women, there is a steady increase in HIV infections while infection for white childbearing women remains stable, according to the Tennessee Department of Health.

Statewide prevalence rates indicate a continued incidence of new HIV infections among childbearing women. The prevalence rate for white childbearing women has remained unchanged at four HIV-infected women per 10,000 births. There was a significant increase in the prevalence rate of African-American childbearing women from 16 HIV-infected women per 10,000 births from April 1989 through March 1990 to 33 HIV-infected women per 10,000 births from April 1992 through March 1993. [6]

From 1982 through October 1993, 28 teens aged 13-19 at the time of their diagnosis with AIDS have been reported in Tennessee. Nine of these teens have died. Fifteen (54 percent) of the 28 teens were white and 13 (46 percent) were African-American. These 28 teens represent 0.8 percent of the total number of persons with AIDS (3,487) reported in Tennessee through October, 1993. Nationally, teens aged 13-19 represent 0.4 percent of all reported persons with AIDS (1,415 of 339,250) through September, 1993.

Sexually active individuals who have unprotected sex with many partners are at serious risk of contracting the HIV virus. In the 1992 Risk Behavior Survey conducted statewide with 3,234 teens, 25 percent of the sexually active teens reported having four or more partners. Of those who had sexual intercourse in the last three months, only 51 percent reported using a condom. [7]

The Tennessee Department of Health estimates that at any point in time, 50 percent or more of persons infected with HIV have not been tested. The exact numbers of Tennesseans infected with HIV at any age, therefore, is unknown.

It is estimated that 14,000 persons in Tennessee are currently infected with the HIV virus, according to the Tennessee Department of Health. In 1993, an estimated 2,000 people became infected, and by the end of 1994, a total of 16,000 will become infected with HIV, as estimated by projections by the Tennessee Department of Health. Nationally, one million persons are estimated to be HIV infected and worldwide estimates are 10 to 12 million infected persons, according to the Centers for Disease Control.

STDs (sexually transmitted diseases)

Teen STD Rate Shows 23 Percent Improvement

Sexually transmitted diseases (STD) present serious risks to many teens. During 1993 in Tennessee, 7,581 teens aged 15-19 were reported having chlamydia, gonorrhea, syphilis, or chanchroid (a bacterial infection), for a rate of 2092.0 per 100,000. The 1992 rate was 2158.8 per 100,000.

The 1993 STD rate for teens is a 23 percent reduction from the 1991 teen STD rate (9,664 teens for a rate of 2636.4). An official with the Tennessee Department of Health said efforts at the state level to improve clinical services to teens with STDs, improved medication, and general education about STDs and HIV in the schools have helped reduce the STD rate.

Although the recent decrease in the teen STD rate is good news, there are still too many teens contracting sexually transmitted diseases.

Nationally, three million teens contract an STD annually, according to estimates by the Centers for Disease Control. One fourth of all adolescents become infected before they graduate from high school. [1]

Adolescents have higher rates of gonorrhea and chlamydia than any other age group. In some areas of the U.S., up to 40 percent of the teen girls have been infected with chlamydia, the most common bacterial STD. More than 200,000 teens nationally aged 15-19 were infected with gonorrhea in 1989 and as many as 44,000 were infected with herpes. [2]

The syphilis infection rate for young people aged 15 to 19 in the U.S. jumped from 15 to 25 per 100,000 between 1985 and 1989, according to the Centers for Disease Control.

STDs have tremendous personal and societal costs. They can cause serious, lasting health problems, including sterility, infertility, cervical cancer, ectopic pregnancies, infections passed on to newborns, or fetal loss. [3] The national aggregated annual costs of herpes, gonorrhea, chlamydia, and pelvic inflammatory disease are estimated to be a total of $8.4 billion, according to the Centers for Disease Control.

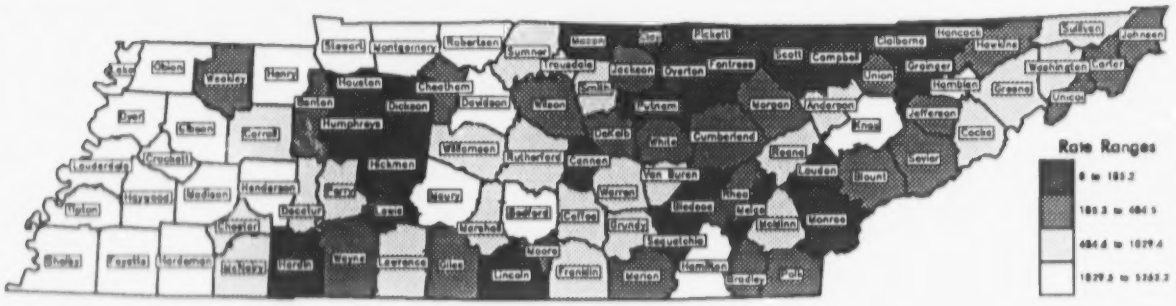
Young women are particularly at great risk for getting an STD. The younger the age at which a girl first enters into sexual relationships, the more likely that negative consequences will follow. Early sexual initiates have more frequent acts of coitus and multiple partners, and are less likely to use effective methods of contraception. [4] The earlier the age of first intercourse, the longer the delay in going to a clinic to obtain contraception. [5]

A young girl may be sexually active and not at risk of pregnancy due to her young age. Increasing numbers of young girls are having coitus prior to their first menstrual periods (menarche). "There has been a downward trend in the age of menarche of about four months per decade since 1850." [6] The average age is 12 1/2 years. Young girls today are reaching menarche at younger ages than they did 100 years ago. Additionally, the rate of early initiation into sexual activity has increased over the course of the century. [7]

One factor that leads very young people to have sex is involvement with drugs. Research has shown that the higher the stage of drug involvement and the earlier the reported initiation into drugs, the greater the probability of early sex. [8] Over the past 20 years, the rates of sexual experimentation, pregnancy, and out-of-wedlock childbearing have increased dramatically among young women ages 15-19. The increased rates in premarital sex and drug use may be related, either because both are influenced by similar factors or because one constitutes a risk factor for the other. [9]

Sexually Transmitted Disease Rate (for Teens 15-19), 1993

Note: This rate is Per 100,000, NOT percent.



County	STD Number	STD Rate
Anderson	38	836.8
Bedford	37	1,666.7
Benton	2	210.1
Bledsoe	1	127.2
Blount	19	319.2
Bradley	26	454.4
Campbell	5	185.2
Cannon	1	137.6
Carroll	13	679.2
Carter	16	435.6
Cheatham	5	247.2
Chester	10	828.5
Claiborne	1	46.3
Clay	0	0.0
Cocke	21	986.4
Coffee	20	703.7
Crockett	11	1,234.6
Cumberland	12	484.5
Davidson	1,282	3,678.1
Decatur	7	1,029.4
DeKalb	2	202.2
Dickson	5	184.7
Dyer	26	1,037.1
Fayette	45	2,164.5
Fentress	0	0.0
Franklin	20	706.2
Gibson	39	1,260.9
Giles	8	402.2
Grainger	2	159.0
Greene	37	947.7
Grundy	9	847.5
Hamblen	45	1,198.7
Hamilton	613	3,098.5

County	STD Number	STD Rate
Hancock	0	0.0
Hardeman	73	4,227.0
Hardin	2	123.3
Hawkins	14	439.6
Haywood	77	5,263.2
Henderson	18	1,198.4
Henry	33	1,864.4
Hickman	0	0.0
Houston	0	0.0
Humphreys	2	183.7
Jackson	2	329.5
Jefferson	8	285.9
Johnson	3	313.2
Knox	383	1,549.5
Lake	11	2,455.4
Lauderdale	40	2,414.0
Lawrence	14	539.5
Lewis	0	0.0
Lincoln	2	99.1
Loudon	4	185.1
McMinn	26	845.8
McNairy	15	1,002.0
Macon	1	90.2
Madison	291	4,846.0
Marion	8	418.8
Marshall	9	564.6
Maury	116	3,027.9
Meigs	1	164.2
Monroe	4	161.7
Montgomery	95	1,153.8
Moore	1	278.6
Morgan	6	442.8
Obion	68	2,887.5

County	STD Number	STD Rate
Overton	1	78.6
Perry	3	660.8
Pickett	0	0.0
Polk	4	394.9
Putnam	6	128.2
Rhea	6	308.3
Roane	19	578.4
Robertson	32	1,079.3
Rutherford	102	928.7
Scott	2	138.9
Sequatchie	0	0.0
Sevier	10	265.0
Shelby	3,279	5,118.4
Smith	6	616.0
Stewart	8	1,197.6
Sullivan	92	943.1
Sumner	47	562.9
Tipton	80	2,650.8
Trousdale	2	495.0
Unicoi	4	358.7
Union	5	476.2
Van Buren	2	581.4
Warren	18	765.0
Washington	63	921.7
Wayne	2	197.6
Weakley	13	435.7
White	6	438.9
Williamson	46	698.5
Wilson	18	351.0
Tennessee	**7,581**	**2,092.0**

Note: There are 44 out-of-state STD cases not included in the state total.
Rate is based on the 1993 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

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Violent Deaths

Firearms Take an Increasingly Larger Percentage of Teen Lives

First, a little perspective: More than 99.9 percent of teenagers do *not* die violent deaths each year in Tennessee. The number of teens who die violently is so relatively small that the rate is calculated per 100,000.

The 1992 teen violent death rate, the most recent year for which complete data are available, is 73.9 per 100,000 - .0739 percent. [1]

However, the number of violent teen deaths is growing somewhat compared to a decade ago. In 1984 there were 253 violent teen deaths, compared to 269 in 1992. [2]

Sadder yet is the fact that most violent teen deaths could be prevented.

In 1992, about 90 percent of the 269 violent teen deaths were the result of either motor vehicle accidents or were firearm-related.

Specifically, 144 were motor vehicle accidents, and 100 were firearm deaths. [3]

The majority of the vehicle accident deaths could have been prevented if more of the teens had been wearing seatbelts.

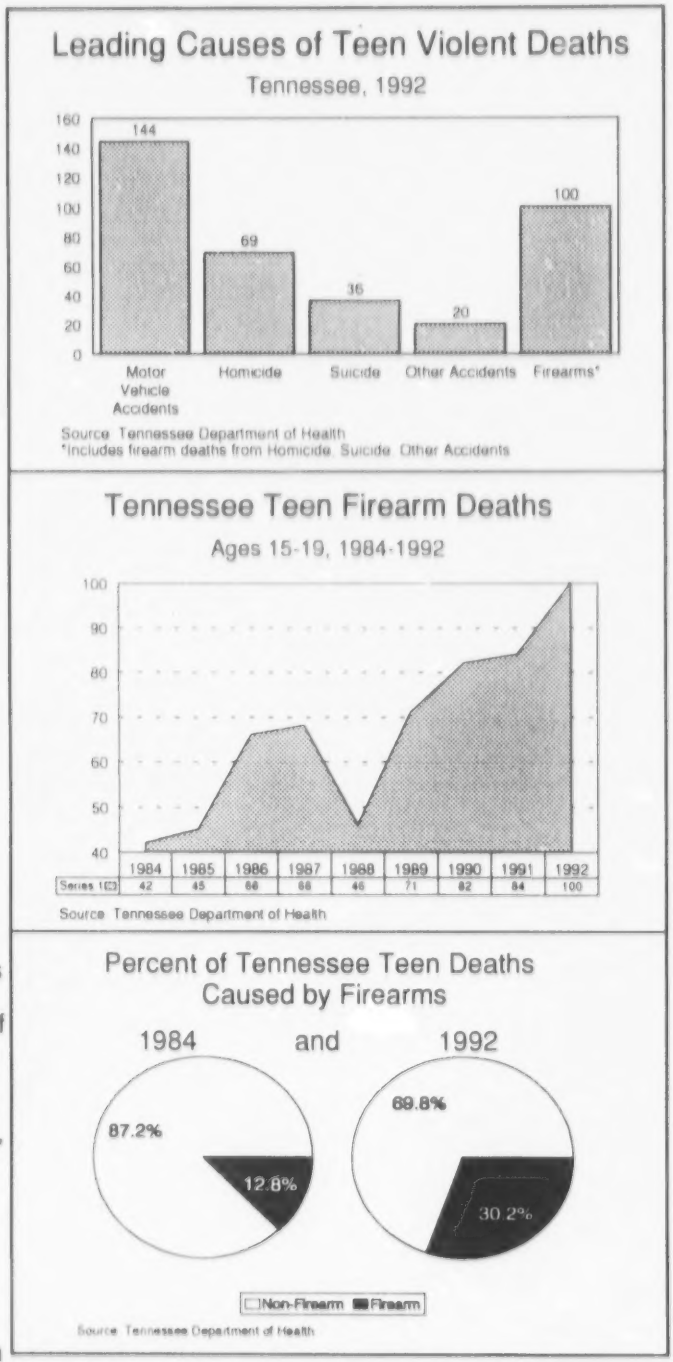
The firearm deaths include suicides, homicides and accidents.

Limiting access to guns for teens could clearly reduce the number of firearm deaths.

However, the number of firearm deaths among teens is growing rapidly, as is the percentage of violent teen deaths that is due to firearms.

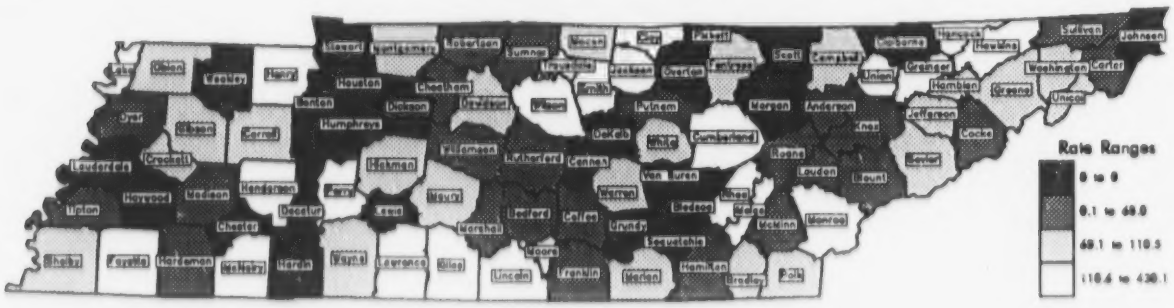
In 1984, 12.8 percent of all teen deaths, including non-violent deaths, were firearm-related. In 1992, 37 percent were. In 1984, 42 of the 328 teen deaths, including non-violent deaths, were firearm related. In 1992 100 of the 331 teen deaths were firearm related. [5]

Forty percent of all teen firearm deaths occurred in Shelby County in 1992, and Shelby County, Davidson, Hamilton and Knox counties together accounted for about 67 percent of all of the state's teen firearm deaths. [6]



Teen Violent Death Rate (Per 100,000 Teens Ages 15-19), 1992

Note: This rate is Per 100,000, NOT percent.



County	Violent Death Number	Violent Death Rate
Anderson	2	43.7
Bedford	1	44.8
Benton	0	0.0
Bledsoe	0	0.0
Blount	4	66.8
Bradley	4	68.9
Campbell	2	72.4
Cannon	0	0.0
Carroll	2	103.4
Carter	1	26.7
Cheatham	1	50.1
Chester	0	0.0
Claiborne	0	0.0
Clay	1	199.6
Cocke	1	46.0
Coffee	1	35.2
Crockett	1	110.5
Cumberland	3	120.3
Davidson	27	77.6
Decatur	0	0.0
DeKalb	0	0.0
Dickson	0	0.0
Dyer	1	39.5
Fayette	3	143.3
Fentress	1	84.5
Franklin	1	34.9
Gibson	3	95.3
Giles	3	150.2
Grainger	2	156.5
Greene	4	100.5
Grundy	0	0.0
Hamblen	3	78.1
Hamilton	13	64.8
Hancock	1	213.2
Hardeman	1	57.4
Hardin	0	0.0
Hawkins	4	122.6
Haywood	0	0.0
Henderson	3	198.2
Henry	2	111.7
Hickman	1	85.5
Houston	0	0.0
Humphreys	0	0.0
Jackson	1	161.0
Jefferson	2	70.1
Johnson	0	0.0
Knox	11	44.4
Lake	2	430.1
Lauderdale	0	0.0
Lawrence	3	115.4
Lewis	0	0.0
Lincoln	4	199.4
Loudon	1	46.0
McMinn	1	32.1
McNairy	2	131.8
Macon	1	89.8
Madison	2	33.3
Marion	2	103.0
Marshall	1	63.1
Maury	4	105.2
Meigs	1	161.0
Monroe	5	198.2
Montgomery	6	74.0
Moore	1	272.5
Morgan	0	0.0
Obion	2	93.0
Overton	0	0.0
Perry	1	217.9
Pickett	0	0.0
Polk	1	94.6
Putnam	3	64.1
Rhea	3	150.9
Roane	1	29.7
Robertson	2	68.0
Rutherford	5	47.2
Scott	0	0.0
Sequatchie	0	0.0
Sevier	3	79.9
Shelby	67	104.5
Smith	2	206.2
Stewart	0	0.0
Sullivan	2	20.0
Sumner	5	60.7
Tipton	1	33.6
Trousdale	1	246.9
Unicoi	1	87.9
Union	3	287.6
Van Buren	0	0.0
Warren	2	84.4
Washington	6	86.4
Wayne	1	97.6
Weakley	0	0.0
White	1	72.5
Williamson	3	47.3
Wilson	6	118.5
Tennessee	**269**	**73.9**
U.S.A.*		**71.1**

Note: Rate is based on the 1992 population estimates made by Department of Sociology, University of Tennessee, Knoxville.

* U.S. rate is for 1991 and from Kids Count: State Profiles of Child Well-being, The Annie E. Casey Foundation, 1994 Baltimore, MD.

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SUMMARY CHAPTER 2: HEALTH

TennCare
- More than 50,000 children ages birth to who were not eligible to be covered under Medicaid are covered by TennCare.
- More than 103,000 girls and women ages 14 to 44 - roughly childbearing age - are now covered and have greater access to prenatal care.
- A total of 385,938 people who were uninsurable or uninsured in Tennessee now have medical insurance through TennCare.

Prenatal Care
- Nearly a third of all births in Tennessee in 1992 lacked adequate prenatal care.
- There are two distinct types of women who fail to get adequate prenatal care: those who make little or no attempt to get prenatal care; and those who try and fail.

Low Birth Weight
- Both the number and percent of babies born in Tennessee weighing less than 5.5 pounds increased from 1990 to 1992. The percentage increased from 8.2 percent of all births in 1990 to 8.5 percent in 1992.
- The number of low-birth-weight babies born in Tennessee grew from 6,160 in 1990 to 6,265 in 1992 - an increase of 105.
- Forty-one counties saw improvements in low-weight births.

Infant Mortality
- Tennessee's infant mortality rate has more or less declined steadily during the past two decades from a rate of 20.3 per 1,000 in 1973 to 9.4 in 1992.
- In 1973, 1,303 Tennessee infants died. In 1992, 691 died.
- The latest figures show the downward trend may be accelerating. From 1990 to 1992 the number of infant deaths in Tennessee decreased by 79 deaths - from 770 in 1990. The rate has declined from 10.3 per 1,000 deaths in 1990 to 9.8 in 1992.

Immunizations
- A survey of 1,690 children aged two years old conducted by the Tennessee Department of Health (TDH) revealed a 72 percent statewide vaccine completion rate in 1993.
- The 1993 immunization rate of 72 percent was a slight increase (1.6 percent) over 1992, but considerably less than the year 2000 goal of 90 percent completion rates.

Child Deaths
- The Tennessee death rate among children ages 1 through 14 years old in 1980 was 44 per 100,000. In 1992, the rate was 31.9 per 100,000.
- In 1990, 333 Tennessee children died, compared to 306 in 1992 - an 8.1 percent reduction.
- Tennessee ranks 39th in the nation in child deaths.
- The primary killer of children is accidents. About 41.5 percent of Tennessee's child deaths were caused by accidents in 1992 - 127 of 306 deaths.

Teen Pregnancy
- Tennessee's 1992 adolescent pregnancy rate dropped to a level not reported since the mid-1980s. The pregnancy rate for 10-17 year olds decreased seven percent to 23.8 pregnancies per 1,000 females, down from 25.6 in 1991.
- Decreases occurred in rates for both white and non-white females from 1991 to 1992. The white rate declined 7.9 percent from 19.1 to 17.6. The non-white rate declined from 48.9 to 45.9, a decrease of 6.1 percent. The most dramatic decrease occurred in the white 15-17 age group, which decreased from 46.5 to 42.8 - an 8 percent decrease.

Drug Abuse
- Alcohol is overwhelmingly the drug of choice among Tennessee teens. Marijuana ran a distant second, and, perhaps surprisingly, cocaine and its various derivatives apparently ran a distant third.
- The 1993 Youth Risk Behavior Survey shows that 76.8 percent of Tennessee high school students have taken at least one drink of alcohol, 32.5 percent have smoked marijuana, and 5.1 percent have taken some form of cocaine.
- The 1990 Youth Risk Behavior Survey showed that 83 percent of Tennessee high school students had taken at least one drink of alcohol, 35.3 percent had smoked marijuana, and 7.1 percent had taken some form of cocaine.

STDs
- During 1993 in Tennessee, 7,581 teens aged 15-19 were reported having chlamydia, gonorrhea, syphilis, or chanchroid (a bacterial infection), for a rate of 2092 per 100,000.

The 1993 STD rate for teens is a 23 percent reduction from the 1991 teen STD rate (9,664 teens for a rate of 2636.4).

Violent Deaths
- The 1992 teen violent death rate, the most recent year for which complete data are available, is 73.9 per 100,000 - .0739 percent.
- The number of violent teen deaths is growing compared to a decade ago. In 1984 there were 253 violent teen deaths, compared to 284 in 1991.
- In 1991, about 85 percent of the 284 violent teen deaths were the result of either motor vehicle accidents or were firearm-related -158 were motor vehicle accidents, and 84 were firearm deaths.
- The number of firearm deaths among teens is growing rapidly, as is the percentage of violent teen deaths that is due to firearms.
- In 1984, 12.8 percent of all teen deaths, including non-violent deaths, were firearm-related. In 1992, 30.2 percent were. In 1984, 42 of the 328 teen deaths, including non-violent deaths, were firearm related. In 1992 100 of the 331 teen deaths were firearm related.

Chapter 3
Education

Enrollment, etc.

Net Enrollment

During the last four years, there have been many changes in Tennessee's schools but what has remained constant is the increase in student enrollment. Overall, there has been a steady, moderate increase in students enrolled in Tennessee public schools. From 1990 to 1993, there has been a six percent increase in net enrollment from 858,991 students in 1990 to 906,451 students in 1993.

Promotion

The four-year trend in grade promotions is similar to net enrollment. There has been a continual, moderate increase in the number of students promoted to the next grade. From 1990 to 1993 there was a three percent increase in grade promotions from 744,484 promotions in 1990 to 772,730 in 1993. The state performance goal for promotion to the next grade from kindergarten through eighth grade is 97 percent.

Retention

For students who fail to be promoted and are retained in the same grade, there was a seven percent increase in 1993 after two years of continuous decline. In 1993 there were 46,299 students retained compared to 43,176 in 1992. From 1991 to 1992 there was a two percent decline from 44,101 students retained in 1991 to 43,176 retained in 1992. There was a three percent decline from 1990 to 1991 with 45,874 students retained in 1990 and 44,101 retentions in 1991.

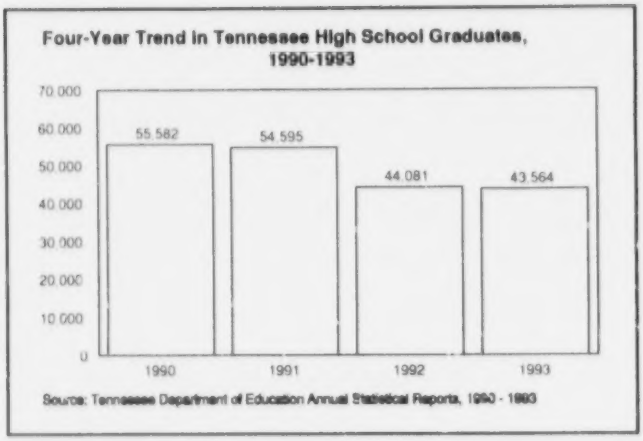
The greatest increase in retentions was at the high school level. There was a 22 percent increase in the number of high school students retained from 1992 (18,599) to 1993 (46,299). Ninth grade had the greatest number of retentions in 1993 with 9,432 students retained - a 35 percent increase from 1992 (6,963 retained). Tenth grade, the second highest, had 6,384 students retained - a 25 percent increase from 1992 (5,102 retained). Eleventh grade had a 14 percent increase in retentions from 1992 (3,535 to 1993 (4,042).

Graduation

From 1990 to 1994, there has been a 21 percent decline in high school graduates with 55,582 graduates in 1990 to 43,564 graduates in 1993. During this four-year period, the most dramatic decline occurred between 1991 and 1992 when there was a 19 percent decline in one year's time. In 1991, there were 54,595 high school graduates and only 44,081 graduates in 1992.

In 1993, there were 34,708 high school students graduating with regular diplomas. Students receiving the regular high school diploma are required to earn 20 units of credit and pass the Tennessee Proficiency Test. The regular diploma is awarded to special education students who have completed an individualized educational program and have passed the Tennessee Proficiency Test.

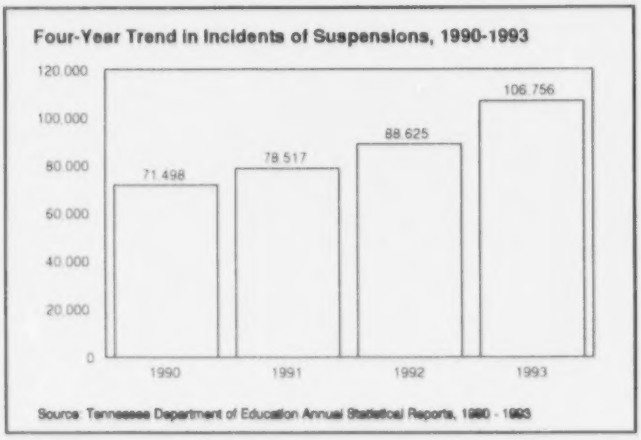
During 1993, there were 7,295 honors diplomas, 1,295 special education diplomas, and 285 certificates of attendance.



School Suspensions

Incidents of school suspensions have risen dramatically with a 49 percent increase from 1990 (71,498) to 1993 (106,756). Reasons for suspensions as reported to the Department of Education include: absenteeism, tardiness and truancy, immoral/disreputable conduct, personal violence, fighting among students, damage to school property, alcohol use, drug use, theft, extortion or gambling, tobacco products, firearm or dangerous weapon.

Although there was a dramatic increase in suspensions from the school year 1989-90 to 1992-93, the overall trend during this time showed a gradual increase each year since 1990. There was a nine percent increase from 1990 (71,517 suspensions) to 1991 (78,517 suspensions). The increase in school suspensions jumped 12 percent between 1991 and 1992 (88,625 suspensions). Between 1992 and 1993, the increase leaped to 20 percent.

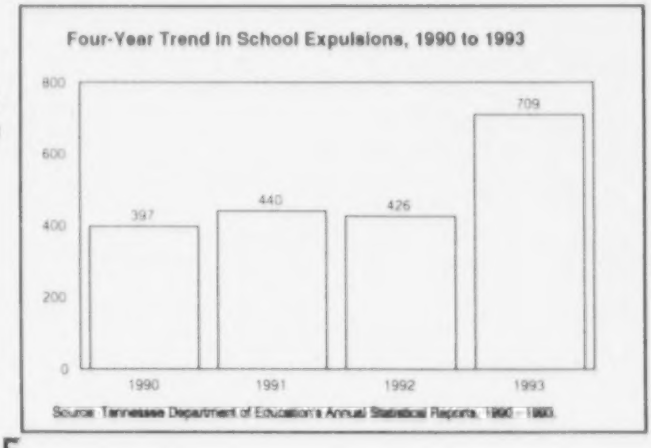


School Expulsions

The number of students expelled from school has increased 78 percent in the four-year period between 1990 and 1994. The reasons for school expulsions are the same as those listed in this report for school suspensions.

From 1990 to 1991, there was a significant 15 percent increase from 397 expulsions in 1990 to 440 in 1991. Between 1991 and 1992, expulsions declined three percent. From 1992 to 1993, there was a dramatic 66 percent increase from 426 in 1992 to 709 school expulsions in 1993.

Among the reasons for expelling a child from school, those reasons which have significantly increased from 1991 to 1993 include: absenteeism, tardiness, and truancy; immoral, disreputable conduct; personal violence; fighting among students; and possession of a firearm or dangerous weapon.



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Student Learning

Students Promoted Without Mastering Grade-Level Skills

TEST RESULTS ON GRADE-LEVEL SKILLS

Many Tennessee students are not mastering grade-level skills, according to the Tennessee Comprehensive Achievement Program (TCAP) test results. This indicates that many students are promoted, yet are unprepared for the next grade.

The part of TCAP that measures grade-level skills, the criterion-referenced portion, reflects the Tennessee math and language arts curricula, and includes only grade-level test items. It was developed specifically for Tennessee students in grades two through eight.

For language arts skills, 57.1 percent of students in grades two through eight mastered their grade-level language arts skills on the 1994 TCAP exam. Third grade had the highest percent of student mastery in language with 68.2 percent mastering third grade language skills. Although eighth grade had the lowest percent of student grade-level mastery with 48.4 percent mastering eighth grade skills, their 1994 TCAP scores improved since the 1993 TCAP when only 47.9 percent mastered grade-level skills.

For math skills, 46.8 percent of students in grades two through eight mastered their grade-level math skills in 1994. This is an increase in 3.5 percent from 1993 when the average was 44.3 percent. Second grade had the highest percent of student grade-level math mastery with 84.7 percent mastery. This is a decline since 1993 when second grade averaged 86 percent mastery. Although seventh grade had the lowest percent of students mastering grade-level math skills with 28 percent mastering seventh grade-level skills, this was an increase since 1993 when only 24.9 percent achieved mastery.

A goal of the 21st Century Schools Plan is for all students to perform at grade level by the year 2000. To achieve this goal, efforts must be made to study the state curriculum, how it is taught and how it is tested.

Continuous curriculum refinements should be made. It is also essential that the most effective instructional strategies for teaching grade-level skills to all students be identified. These strategies could be presented during teacher inservice training.

TCAP results should be analyzed to ensure that TCAP is a reliable and valid measure of what students have learned from the state curriculum. Consideration should be given to testing conditions such as when and how TCAP is administered. When a test is given is a critical factor in getting optimum student achievement and should be considered carefully by teachers and principals. A test administrator's attitude about or behavior during testing may unduly influence test results. A test administrator who is very anxious about the test results may inadvertently make the students anxious. Test anxiety has been shown to have a negative effect on test results.

TEST RESULTS FOR NATIONAL COMPARISON

Overall, Tennessee students are performing within the average range compared to other students in the nation, according to the 1994 TCAP results. That portion of TCAP used for national comparison is the norm-referenced test for students in grades two through eight and ten. It reflects as comprehensively as possible the curricula of schools throughout the country.

Norm-referenced test items on TCAP include those at grade-level skills as well as those above and below grade level. These test items assess student knowledge in math, reading, language, science, social studies, study skills and spelling.

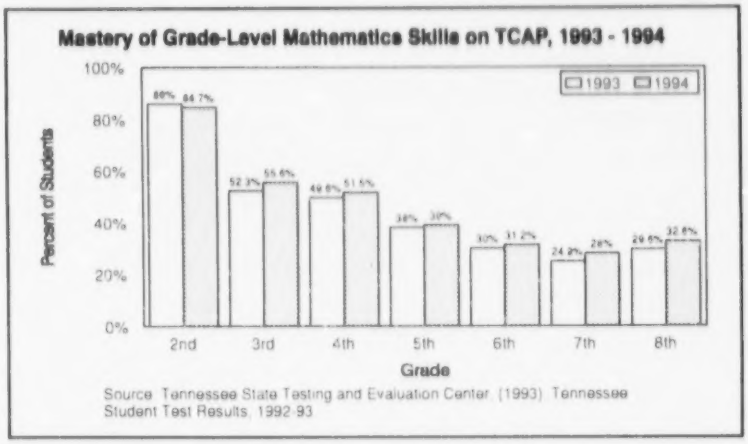
For five years, Tennessee students have scored at or above the average range on 98 percent of the nationally normed test items. In technical terms, the scores clustered in the 5th and 6th stanines. Stanine scores of 1, 2, and 3 are considered below average; 4, 5, and 6 are average; and 7, 8, and 9 are above average.

Nationally, 23 percent of the student population falls in the above average stanines on each subtest. The percent of Tennessee students scoring in the above average range is higher than the national average in 85 percent of the subtests.

To summarize, a goal of the 21 Century Schools program is to achieve an average

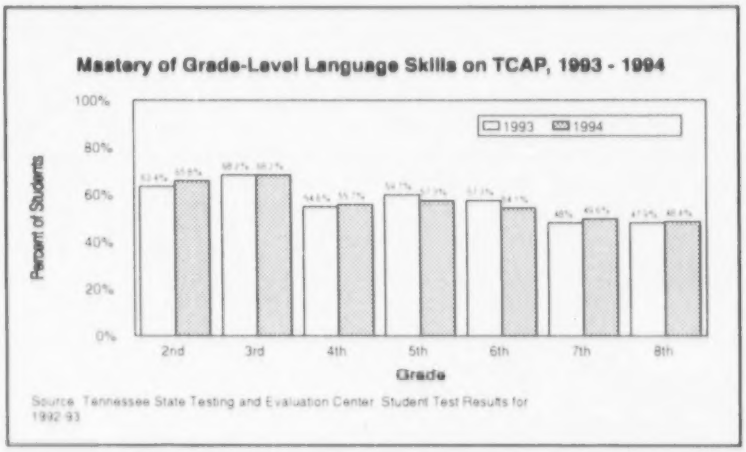
gain equal to or greater than the national average on standard achievement tests in reading, language, math, science, and social studies. To attain this goal, efforts must be made to ensure that all students master essential grade-level skills as well as other skills assessed on TCAP.

To resolve the dilemma of adequate student performance on the norm-referenced portion of TCAP yet inadequate mastery of grade-level skills, the Tennessee Department of Education recommends that educators use TCAP as an instructional tool. Educators are given inservice training to identify students' academic strengths and weaknesses using TCAP scores. When analyzing the test results, deficiencies should be identified and a plan for re-teaching specific skills should be developed to help each student achieve mastery over subject areas in which they are deficient.



Source: Tennessee State Testing and Evaluation Center. (1993). Tennessee Student Test Results, 1992-93.

To follow the Department of Education's recommendation, teachers must be well-trained in using TCAP as a diagnostic tool. Class size must be held to the minimum. With smaller class size, teachers are better able to individualize instruction. By providing teachers with good training in using test scores and smaller classes that are more manageable, each child stands a better chance to master essential grade-level skills.



Source: Tennessee State Testing and Evaluation Center. Student Test Results for 1992-93.

TENNESSEE PROFICIENCY TEST

Students must pass the Tennessee Proficiency Test to receive a regular high school diploma. The proficiency requirement was established in 1981 by the Tennessee State Board of Education and endorsed by the Tennessee General Assembly to ensure that students who graduate from public high schools with regular high school diplomas have demonstrated competency in a common set of basic skills. {17}

The General Assembly amended the proficiency requirement in 1988 to allow, with State Board of Education approval, fulfillment of this requirement through satisfactory performance on specific TCAP math and language arts test items in the criterion-referenced component of the eighth grade TCAP.

For the fourth year, Tennessee Proficiency Test results include students who satisfied the test requirement by meeting the eighth-grade TCAP screening criteria. These scores are reported with the ninth graders who took the Tennessee Proficiency Test for the first time in the spring of 1994. Among eighth graders who met the screening criteria, the 1994 test results showed that Richard City in Marion County had 100 percent of its eighth graders meet the proficiency requirement on the eighth-grade TCAP.

The statewide results showed 76 percent of the test takers passed both the language arts and math subtests of the Tennessee Proficiency Test in 1994. Fentress County, with 96 percent passing both subtests, had the highest percent of students pass. Hancock County had the lowest percent of students passing both parts - 51 percent.

For the math subtest, the statewide results revealed that 86 percent passed. In the South Carroll Special School District, 100 percent passed the math subtest - the highest percent among the 139 school systems. Claiborne County had the lowest percent of student passing math - 68 percent.

On the language arts subtest, Fentress County had 97 percent passing the subtest - the highest percent among the school systems. Fayette County had the lowest percent passing the language arts portion - 61 percent.

ACT Scores

State ACT Scores Near National Average

The majority of college-bound students in Tennessee take the American College Testing (ACT) Program for admission to public colleges and universities. The Scholastic Aptitude Test (SAT), a college admissions test used primarily by non-public colleges and universities, is not as widely administered in Tennessee. Only 13 percent of Tennessee's graduating seniors took the SAT in 1993.

The ACT is a complex and comprehensive assessment that provides an amazing amount of information on Tennessee high school students who may enter colleges and universities. The results of the ACT reveal how college-bound students in Tennessee compare to their peers across the nation. The assessment measures student achievement in skills developed in high school. Background information on the students, their interests in particular careers, and results on their academic assessments are provided. Additionally, the ACT score is predictive of a student's ability in college-level courses.

There are three components of the ACT. The first part is comprised of four subtests that measure academic ability: English, mathematics, reading, and scientific reasoning. The ACT also has a lengthy Student Profile section that provides background information on the students taking the ACT. The third portion of the assessment is the Interest Inventory that measures students' preferences and categorizes them into general career or occupational areas.

Information from the ACT provides data for students in their educational and vocational planning and provides equal educational opportunities for students. For postsecondary institutions, ACT data aids in advisement and counseling in postsecondary planning, college recruitment and retention, and helps simplify admission systems.

A Profile of Tennessee Students

In 1993, 31,064 juniors and seniors took the ACT in Tennessee out of the total junior and senior classes' enrollment of 108,669 students. Seventy-six percent of these students were seniors and 23 percent were juniors. Nationally, 65 percent were seniors and 34 percent were juniors.

Regarding ethnic origin, 73 percent of the Tennessee students were white compared to 71 percent nationally. Fifteen percent of the Tennessee test takers were African American compared to nine percent nationally. Three percent of the students were either Native Americans, Asians or members of other ethnic groups in Tennessee, compared to 6 percent nationally. Nine percent of the students in Tennessee did not respond to the question of their ethnic origin.

A standard score scale is used for reporting scores on the four ACT academic tests. On the four separate academic tests, the statewide average composite score was 20.2. The national composite average was 20.7.

A profile of the 31,064 Tennessee students who took the ACT in 1993 shows that many students who took the assessment have high academic aspirations. Forty-five percent reported seeking either a graduate degree or a professional degree - the national average was 44.2 percent. Thirty-four percent want a bachelor's degree in Tennessee compared to 19.7 percent nationally. Other students were pursuing either vocational/technical training, associate's degrees, or other postsecondary training.

Eighty-five percent of the Tennessee students reported their grade point average above 2.0 compared to 87 percent nationally. Sixty-eight percent reported being in the top half of their graduating classes with 35 percent in the top quarter. Nationally, 72 percent reported being in the top half of their classes with 40 percent in the top quarter.

Fifty percent of the Tennessee students reported an estimated annual family income greater than $30,000 compared to 56 percent of the students in the rest of the country. Seventy-six percent of the Tennessee students expressed the need for financial aid in college while 79 percent of students nationally expressed the same need. Sixty-two percent of the Tennessee students stated they needed to find work while in college to help meet their expenses, compared to 66 percent of students nationally.

Average ACT Composite* Scores, 1993

County	ACT Composite	
	Number	Average
Anderson	500	21.4
Bedford	217	20.3
Benton	86	19.7
Bledsoe	40	18.8
Blount	506	21.1
Bradley	418	20.0
Campbell	137	18.7
Cannon	45	19.2
Carroll	202	19.8
Carter	277	19.8
Cheatham	137	20.0
Chester	80	22.0
Claiborne	135	19.6
Clay	42	19.4
Cocke	159	19.6
Coffee	293	20.9
Crockett	45	18.9
Cumberland	161	20.8
Davidson	2,695	20.4
Decatur	46	18.7
DeKalb	74	19.2
Dickson	202	20.1
Dyer	228	19.6
Fayette	150	17.5
Fentress	96	19.8
Franklin	249	19.9
Gibson	295	19.9
Giles	170	19.6
Grainger	57	18.9
Greene	317	19.6
Grundy	83	18.6
Hamblen	329	19.9
Hamilton	1,896	20.8

County	ACT Composite	
	Number	Average
Hancock	22	0.0
Hardeman	154	18.6
Hardin	150	19.7
Hawkins	227	19.9
Haywood	118	18.1
Henderson	135	20.2
Henry	160	19.7
Hickman	87	20.0
Houston	40	18.6
Humphreys	120	20.0
Jackson	39	20.6
Jefferson	193	19.9
Johnson	40	19.0
Knox	1,953	21.0
Lake	24	0.0
Lauderdale	140	19.1
Lawrence	200	20.1
Lewis	64	19.6
Lincoln	151	19.9
Loudon	214	19.9
McMinn	259	20.2
McNairy	152	20.6
Macon	92	19.5
Madison	564	20.2
Marion	133	19.4
Marshall	141	19.6
Maury	408	19.9
Meigs	51	18.7
Monroe	194	19.2
Montgomery	540	20.2
Moore	20	0.0
Morgan	87	19.0
Obion	237	20.3

County	ACT Composite	
	Number	Average
Overton	87	19.5
Perry	39	19.3
Pickett	24	0.0
Polk	74	20.2
Putnam	324	20.9
Rhea	137	20.2
Roane	303	20.3
Robertson	306	19.7
Rutherford	787	20.6
Scott	129	20.0
Sequatchie	58	19.0
Sevier	358	20.5
Shelby	6,167	19.7
Smith	102	19.4
Stewart	58	19.6
Sullivan	1,013	21.1
Sumner	793	20.6
Tipton	276	19.3
Trousdale	34	19.9
Unicoi	112	19.1
Union	48	18.9
Van Buren	11	0.0
Warren	162	20.6
Washington	489	20.9
Wayne	65	20.0
Weakley	198	19.2
White	106	19.0
Williamson	805	21.9
Wilson	508	19.7
Tennessee	**31,064**	**20.2**
U.S.A.	**875,603**	**20.7**

Note: * Average composite score is the average of the four ACT subtests; reading, mathematics, English, and scientific reasoning.

Source: Department of Program Evaluation and Institutional Research Services, American College Testing, 1994.

Special Education

Use of Special Education Services Increasing

During the 1992-93 school year, 159,513 children received special education services in Tennessee public schools - 17.6 percent of the total school population. This figure includes 18,626 gifted children. A gifted child is one whose intellectual abilities and potential for achievement are so outstanding that special provisions are required to meet the established educational needs.

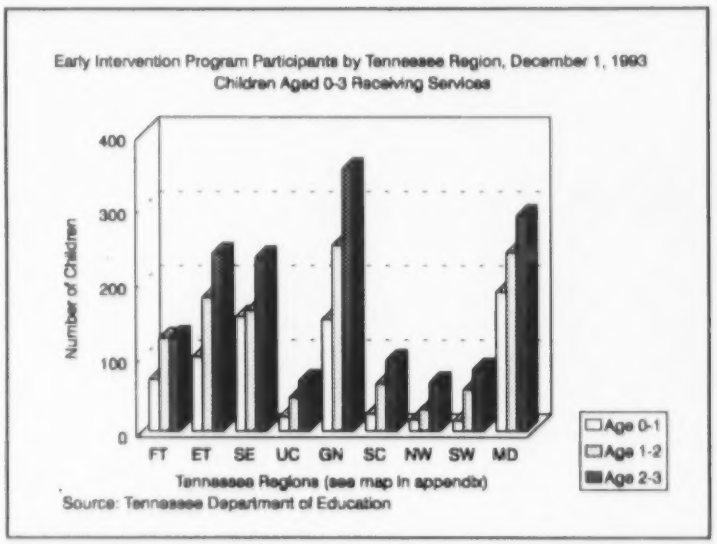
Compared to 1990-91 school year, the total number of children receiving special education services during 1992-93 represents a 13 percent (140,967 students) increase in number of students served. When looking at specific handicapping conditions to account for the difference in these two school years, dramatic increases are apparent in the number of children served with health impairments and severe emotional disturbances.

There was a 66 percent increase in health impaired children served from 1990-91 (2,984 children) to 1992-93 (4,951). Health impairment refers to a child who has "limited strength, vitality or alertness due to chronic or acute health problems, such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes which adversely affects his or her educational performance. [1]

There was a 27 percent increase in the number of children with severe emotional disturbances from 1990-91 (2,922 children) to 1992-93 (3,733). For a child to receive services for severe emotional disturbances, the child must exhibit one or more of the following:

1. Inability to learn which cannot be explained primarily by intellectual, sensory, health, or specific learning disability factors.
2. Inability to build or maintain satisfactory interpersonal relationships with peers, teachers, and other significant persons.
3. Inappropriate types of behavior or feelings under normal circumstances.
4. General pervasive mood of unhappiness or depression.
5. Tendency to develop physical symptoms or fears associated with personal or school problems. [2]

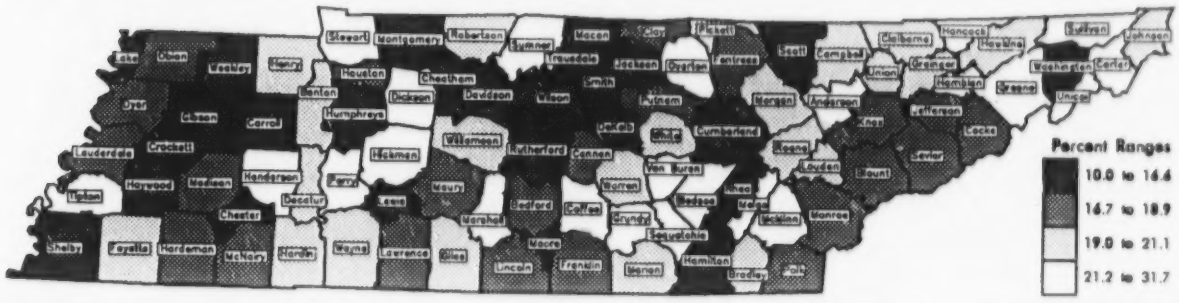
One reason for the increase is more children are being identified as being in need of special help. Early identification is needed "to detect a child's disability prior to school age so that appropriate services can be provided for the child and, if warranted, for the family. Longitudinal research has demonstrated that the earlier a child's disability is identified and appropriate services are provided, the less extensive are the problems caused by the disability." [3]



Child identification is the first step toward providing full and appropriate services for children with disabilities. Local school systems are required to identify, locate, and evaluate all children within their jurisdictions, ages birth through 21, who may be in need of special education and related services.

Most children with obvious and/or severe disabilities are located and "identified easily because they have been served by local treatment and health care agencies. In planning a child-find and public awareness campaign, special effort should be made to find hard-to-reach children whose parents may not be aware of the need for, and availability of, early intervention services. Methods should also be planned to reach persons in the community who may not understand English language materials and broadcasts and persons living in rural or isolated geographic areas." [4]

Percent of Students Receiving Special Education, 1992-1993



County	Special Education	
	Number	Percent
Anderson	3,495	26.2
Bedford	1,146	18.9
Benton	515	19.3
Bledsoe	486	26.8
Blount	3,032	18.8
Bradley	2,828	19.5
Campbell	1,284	19.0
Cannon	378	18.9
Carroll	898	16.6
Carter	2,160	24.4
Cheatham	844	13.5
Chester	387	15.8
Claiborne	1,060	20.5
Clay	234	17.4
Cocke	1,056	18.5
Coffee	2,319	25.8
Crockett	370	14.1
Cumberland	1,073	15.8
Davidson	10,427	14.4
Decatur	364	19.3
DeKalb	383	13.4
Dickson	1,629	21.8
Dyer	1,317	18.4
Fayette	1,074	20.9
Fentress	439	17.8
Franklin	1,138	17.9
Gibson	1,472	16.6
Giles	955	19.6
Grainger	675	20.9
Greene	2,048	21.5
Grundy	814	30.3
Hamblen	2,292	23.7
Hamilton	7,511	15.3

County	Special Education	
	Number	Percent
Hancock	295	22.8
Hardeman	897	16.8
Hardin	839	19.9
Hawkins	1,527	19.9
Haywood	569	13.4
Henderson	950	21.7
Henry	987	19.0
Hickman	775	23.9
Houston	243	17.4
Humphreys	501	16.0
Jackson	232	14.7
Jefferson	1,027	17.0
Johnson	508	20.0
Knox	9,707	17.5
Lake	181	14.3
Lauderdale	935	17.6
Lawrence	1,181	17.2
Lewis	331	16.3
Lincoln	992	17.3
Loudon	1,248	20.2
McMinn	1,980	23.1
McNairy	729	16.9
Macon	406	12.6
Madison	2,662	17.7
Marion	1,027	19.6
Marshall	997	22.2
Maury	1,973	16.9
Meigs	502	29.8
Monroe	1,056	17.0
Montgomery	3,180	15.4
Moore	131	13.4
Morgan	721	20.1
Obion	1,088	18.0

County	Special Education	
	Number	Percent
Overton	734	23.3
Perry	279	22.9
Pickett	173	19.8
Polk	451	18.7
Putnam	1,580	17.3
Rhea	659	13.5
Roane	1,754	21.1
Robertson	1,831	20.3
Rutherford	4,401	16.5
Scott	759	16.6
Sequatchie	540	31.7
Sevier	1,907	18.4
Shelby	19,539	12.4
Smith	302	10.0
Stewart	386	22.1
Sullivan	5,953	23.9
Sumner	4,843	23.0
Tipton	2,057	21.2
Trousdale	175	14.6
Unicoi	751	26.5
Union	525	20.1
Van Buren	206	23.8
Warren	1,305	19.7
Washington	2,474	16.6
Wayne	611	21.0
Weakley	824	15.8
White	730	19.9
Williamson	3,306	20.2
Wilson	2,039	14.1
Tennessee	**157,574**	**17.4**

Source: Tennessee Department of Education.

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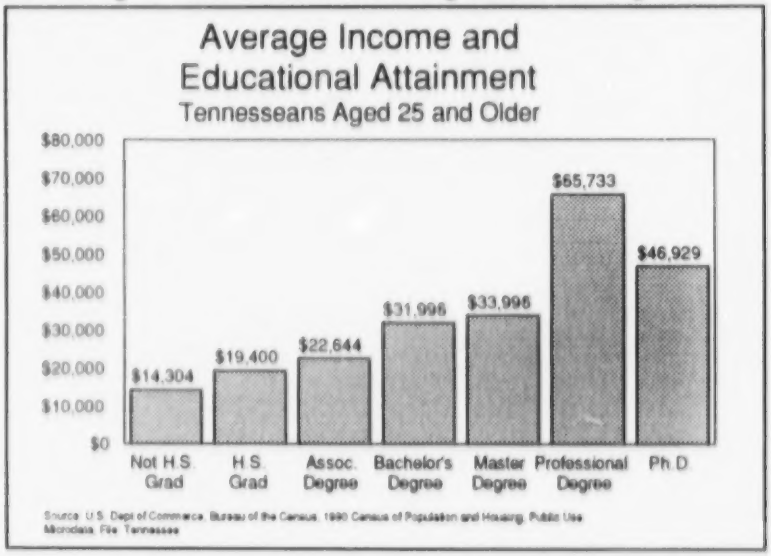
Dropping Out

Number of Dropouts in Tennessee Decreasing

High school dropouts, as reported here, are the percent of students who drop out of grades 9-12 in a calendar year. The dropout rate is calculated by dividing the number of dropouts within the year by the net student enrollment at the end of the school year.

Getting an education is the principal route to a satisfying adult life in the U.S. Increasingly, failure to complete school is a "powerful precursor of long-term disadvantage." [1]

Dropouts face serious, long-term economic consequences resulting from their decisions to quit school. They experience higher job turnover, unemployment, and earn much less than their counterparts who either finished high school or college. The unemployment rate in 1990 for dropouts (8.5 percent) was almost two times greater than the unemployment rate for individuals with a high school diploma (4.9 percent). [2] Each male dropout will earn on average $260,000 less and pay $78,000 less in taxes during his lifetime than those who graduate from high school. For a female dropout, the figures are $200,000 and $60,000, respectively. [3]

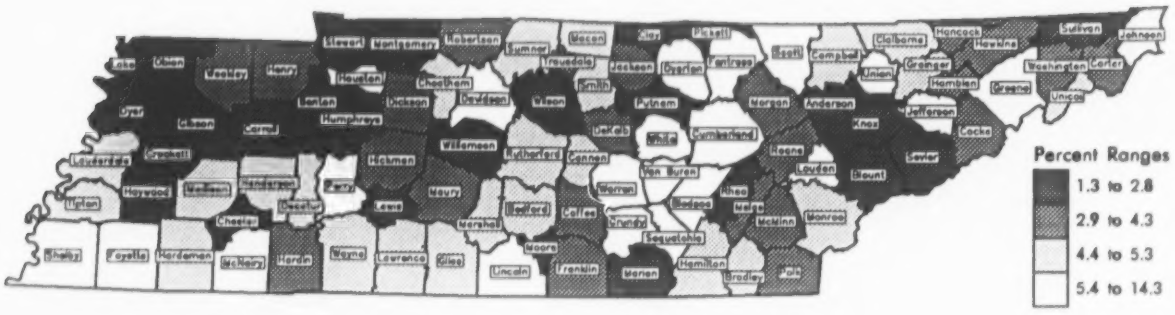


Gov. Ned McWherter initiated two of the three recently enacted laws to help keep teens in school until they graduate. A 1992 law was enacted which increased the age of mandatory school attendance from age 16 to 17. [4] The other two laws use the driver's license as an incentive for students to stay in school. A law enacted in 1990 denies a learner's permit or driver's license to any teen under 18 years old who drops out of school and is not pursuing a general educational development (GED) certificate. [5] The second law using the driver's license incentive was passed in 1994. It requires that dropouts returning to school must meet specific academic performance standards to get their driver's licenses. The returning student must attend school for a complete grading period and pass three courses before the student is eligible to obtain a driver's license.

Recent legislation and educational efforts to reduce the number of dropouts in the state have been successful. The percentage of dropouts declined from 6.3 percent in 1991-92 to 4.8 percent in 1992-93. In 1992-93, there were 11,832 dropouts compared to 15,223 dropouts in 1991-92.

Although the decline in number of dropouts is good news, the 11,832 teens who failed to complete their high school education are at a serious disadvantage in the contemporary work place. Today's working environment requires higher levels of literacy, more education, increased technological skills, and, most importantly, the ability to begin careers that require lifelong learning. People who do not complete high school are faced with a lifetime of limited opportunities. [6]

Percent of High School (Grades 9-12) Dropouts, 1992-1993



County	Dropouts	
	Number	Percent
Anderson	108	2.8
Bedford	90	5.2
Benton	16	2.0
Bledsoe	61	14.3
Blount	116	2.6
Bradley	216	5.2
Campbell	88	4.4
Cannon	27	4.8
Carroll	24	1.5
Carter	89	3.3
Cheatham	81	4.8
Chester	16	2.2
Claiborne	64	4.6
Clay	7	1.6
Cocke	59	3.7
Coffee	104	4.0
Crockett	19	2.8
Cumberland	144	6.6
Davidson	1,386	8.0
Decatur	28	4.5
DeKalb	28	3.9
Dickson	89	4.3
Dyer	39	1.9
Fayette	89	6.5
Fentress	19	7.8
Franklin	74	4.2
Gibson	64	2.5
Giles	63	4.6
Grainger	44	4.4
Greene	190	6.2
Grundy	68	8.2
Hamblen	89	3.2
Hamilton	587	5.1

County	Dropouts	
	Number	Percent
Hancock	12	3.4
Hardeman	71	4.6
Hardin	55	4.3
Hawkins	72	3.3
Haywood	33	2.6
Henderson	65	5.2
Henry	45	3.0
Hickman	32	3.5
Houston	27	5.7
Humphreys	24	2.5
Jackson	20	3.9
Jefferson	98	5.7
Johnson	42	5.5
Knox	420	2.6
Lake	10	2.7
Lauderdale	63	4.5
Lawrence	108	5.3
Lewis	10	1.8
Lincoln	98	6.5
Loudon	120	6.2
McMinn	91	3.6
McNairy	74	5.4
Macon	43	4.9
Madison	210	5.1
Marion	27	1.7
Marshall	56	4.4
Maury	131	4.2
Meigs	20	3.7
Monroe	95	4.9
Montgomery	135	2.6
Moore	6	2.0
Morgan	35	3.3
Obion	49	2.6

County	Dropouts	
	Number	Percent
Overton	64	6.8
Perry	20	5.7
Pickett	3	1.3
Polk	32	4.2
Putnam	43	1.7
Rhea	19	1.4
Roane	91	3.5
Robertson	74	3.3
Rutherford	341	5.0
Scott	76	5.7
Sequatchie	31	5.8
Sevier	74	2.6
Shelby	2,904	7.4
Smith	36	4.5
Stewart	15	2.8
Sullivan	197	2.6
Sumner	303	4.7
Tipton	109	4.4
Trousdale	11	3.2
Unicoi	46	5.3
Union	83	12.0
Van Buren	13	5.6
Warren	190	11.3
Washington	140	3.1
Wayne	44	5.2
Weakley	61	4.1
White	59	5.5
Williamson	81	2.0
Wilson	89	2.4

Tennessee	**11,832**	**4.8**

Source: Tennessee Department of Education.

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School Violence

What Causes School Violence, and How Does it Affect Teens?

The last haven of safety for many children has been the school. With the increase in violent acts in school and greater numbers of students carrying guns, many students are fearful.

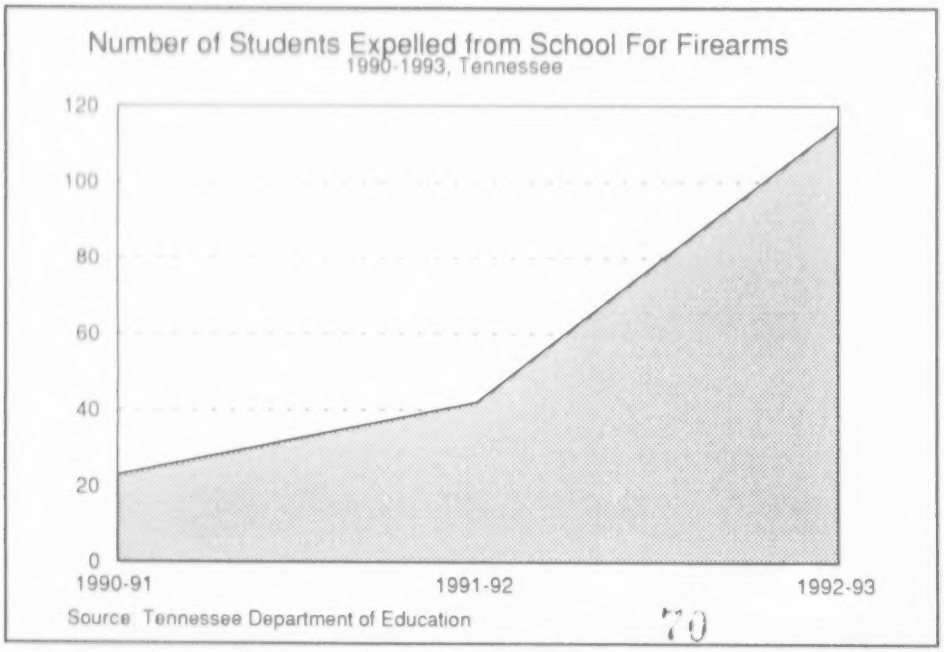
Students' fear of violence is not unjustified. Possession of firearms in schools is a serious and growing problem in Tennessee schools that is growing. There were more than five times more students expelled for possession of firearms and other dangerous weapons during the 1992-93 school year compared to 1990-91 in Tennessee. During 1990-91, there were 33 expulsions compared to 173 expulsions in the 1992-93 school year.

Guns in school represent a threat to everyone. On April 21, 1994, a 7th grade student at a Metropolitan Nashville/Davidson County school was shot in the back of his head and killed during music class while watching *Beauty and the Beast*.

The student seated behind him shot him with a .25 caliber automatic pistol, which police believe went off accidentally. This tragedy has left students, parents, educators, and the public fearful about school safety and the availability of guns.

When students don't feel safe, it is hard for them to learn. Acts of violence disrupt the normal functioning of the school, and the fear of violence can prevent students and teachers from concentrating on meaningful learning and teaching.

The academic achievement of students who don't feel safe at school suffers in comparison to those who feel safe. A 1993 survey of 6th, 7th, and 8th graders showed that students who did not feel safe scored significantly lower on the Tennessee Comprehensive



Assessment Program tests than students who felt safe.

Violent acts or the threat of violence against other students and school personnel have more than doubled the number of school expulsions and substantially increased the number of incidents of suspension within the past three years. The number of expulsions rose from 37 in 1990-91 to 85 expulsions in 1992-93.

Consider the following findings on school violence:

• One large national study showed that junior (vs. senior) high schools, and schools with more male students, larger enrollments, and larger classes experienced more violence, as did schools lacking strict and fair administration of discipline. [1]

• Another study by the National Research Council cites four characteristics of schools that may contribute to violence:

1. relatively high numbers of students occupy a limited amount of space;
2. the capacity to avoid confrontations is somewhat reduced;
3. the imposition of behavioral routines and conformity may contribute to feelings of anger, resentment, and rejection; and
4. poor building design may facilitate the commission of violent acts. [2]

Students' attitudes about school may also contribute to school violence. Research has shown that school violence is more prevalent where students:

1. felt their classes did not teach them what they wanted to learn;
2. did not consider their grades important;
3. did not plan to go to college; and
4. felt they had no influence over their own lives. [3]

The possession, use and sale of illegal drugs is another serious problem that is growing. The number of school suspensions in Tennessee for the possession, use or sale of illegal drugs more than doubled from 1990-91 to 1992-93. The number of suspensions in 1990-91 was 809. In 1992-93, there were 1,780 suspensions for drug-related problems.

How do teens become violent?

Research shows that there are at least 11 factors that contribute to violent behavior: biological factors; child rearing conditions; ineffective parenting; emotional and cognitive development; gender differences; sex role socialization; relations to peers; cultural milieu; social factors (i.e., economic inequality, lack of opportunity); and media influences. [4]

Factors contributing to the development of antisocial behavior include family characteristics and a breakdown of family processes and relationships, including violence. "Criminal history or antisocial personality in a parent, parental rejection of the child, and inconsistent and physically abusive parental discipline all seem to contribute to early aggressive behaviors. Lack of parental supervision is one of the strongest predictors of the development of conduct problems and delinquency. Parents who support the use of aversive and aggressive behaviors by children and fail to teach nonviolent and effective methods of solving social problems contribute to the development of coercive family interactions and to later patterns of antisocial behavior in the child." [5]

"Personal, family, school, and societal factors all contribute to school violence. Efforts to reduce school violence must consider these multiple sources of the problem." [6]

SUMMARY CHAPTER 3: EDUCATION

Enrollment

• There has been a steady, moderate increase in students enrolled in Tennessee public schools. From 1990 to 1993, there has been a six percent increase in net enrollment from 858,991 students in 1990 to 906,451 students in 1993.

Student Learning

• For language arts skills, 57.1 percent of students in grades two through eight mastered their grade-level language arts skills on the 1994 TCAP exam.

• Third grade had the highest percent of student mastery in language with 68.2 percent mastering third grade language skills.

• Although eighth grade had the lowest percent of student grade-level mastery with 48.4 percent mastering 8th grade skills, their 1994 TCAP scores improved since the 1993 TCAP when only 47.9 percent mastered grade-level skills.

• 46.8 percent of students in grades two through eight mastered their grade-level math skills in 1994. Second grade had the highest percent of student grade-level math mastery with 84.7 percent mastery.

ACT Scores

• Tennessee's average ACT scores in 1993 were near the national average.

Dropping Out

• The percentage of dropouts in Tennessee declined from 6.3 percent in 1991-92 to 4.8 percent in 1992-93. In 1992-93, there were 11,832 dropouts compared to 15,223 dropouts in 1991-92.

School Violence

• There were more than five times more students expelled for possession of firearms and other dangerous weapons during the 1992-93 school year compared to 1990-91 in Tennessee. During 1990-91, there were 33 expulsions compared to 173 expulsions in the 1992-93 school year.

References

Single-Parent Families

1. The Annie E. Casey Foundation, (1994). Kids Count Data Book: State Profiles of Child Well-Being. Baltimore, Maryland, p. 117.
2. Ibid., p. 81.
3. Ibid., p. 117.
4. Ibid., pp. 85, 79, 101, and 115.
5. Ibid., p. 16.
6. Ibid.
7. Millar, J., (1989). Poverty and the Lone-Income Family: The Challenge to Social Policy. Bath, England: University of Bath's School of Social Sciences, p. 6.
8. Zill, N., and Nord., C.W., (1994). Running in Place: How American Families are Faring in a Changing Economic and Individualistic Society. Washington, DC: Child Trends Inc., p. 3.

Poverty/Income

1. Poverty engulfing more children, fewer seniors, (1994, October 11). The Tennessean, p. 4a.
2. Ibid.
3. The Annie E. Casey Foundation, (1992). Handout on children in poverty for the Kids Count project.
4. Ibid., p. 2.
5. Zill, N. And Nord., C.W. (1994). Running in Place: How American Families are Faring in a Changing Economic and Individualistic Society. Washington, DC: Child Trends, Inc., p. 82.

AFDC

1. Axinn, J.M. and Hirsh, A.E., (1993). Publication on Families in Society from The Journal of Contemporary Human Services, p. 565.
2. Center on Social Welfare and Law, (1994, June). Living at the Bottom: An Analysis of 1994 AFDC Benefit Levels. New York City.
3. Ibid.
4. Ibid.
5. Center for Business and Economic Research, (1994, March). Aid to Families With Dependent Children: 1993 Case Characteristic Study. University of Tennessee: Knoxville, Tennessee.
6. Ibid.

Nutrition

1. Center on Hunger, Poverty, and Nutrition Policy, (1993, Fall). A Statement on the Link Between Nutrition and Cognitive Development. Medford, MA: Tufts University, School of Nutrition, p. 14.
2. Food Research and Action Center, (1993). School Breakfast Score Card: 1992-1993. Washington, D.C.
3. Center on Hunger, Poverty, and Nutrition Policy's 1993 report, p. 9.
4. Ibid.
5. Ibid., p. 10
6. Ibid., p. 5.
7. Ibid.
8. Ibid.

Teen Employment

1. Jacobs., H.N., (1990). The Advantages and Disadvantages of Teenage Employment on Student Achievement. Unpublished research for Trevecca Nazarene College, Nashville, Tennessee.
2. President's Science Advisory Committee's Panel on Youth, (1973). Youth: Transition to Adulthood. Washington, D.C.
3. Workman, B., (1990). Dear professor: this is what I want you to know. Phi Delta Kappan, 48, 668-671.

Domestic Violence

1. Jaffe, Wolfe, Wilson, (1990). Children of Battered Women. Newbury Park, CA: Sage Publications, p. 4
2. Straus, M.A., Gelles, R.J., and Steinmetz, S.K., (1980). Behind Closed Doors: Violence in the American Family. Garden City, NY: Anchor Press.
3. Ibid.
4. Ibid.
5. The News Beacon, (1994, June 29). Nashville, TN, p. 1.
6. Novello, A.C., (1992). "From the Surgeon General, U.S. Public Health Service," The Journal of the American Medical Association, 267(23), p. 3,132.
7. Ibid.
8. Ibid.

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9. Jaffe, Wolfe, and Wilson's 1990 publication, Children of Battered Women, p. 21.
10. Ibid., p. 17.
11. Ibid.
12. Ibid.
13. Ibid., p. 22.
14. Fact sheets by the National Woman Abuse Prevention Project on the effects of domestic violence on children. Undated publication.
15. Hewlett, S.A., (1991). When the Bough Breaks. Basic Books, p. 279.
16. Ibid.
17. Ibid.
18. Ibid., p. 7.

Child Abuse

1. Tennessee Department of Human Services, (1993, December). Facts About Child Abuse. Nashville, Tennessee.
2. Ibid.
3. Tennessee Department of Human Services, (1992, September 10). Questions and Answers About Child Protective Services.

Teen Crime

1. Tennessee Children's Services Commission, (1984). Tennessee Annual Juvenile Court Statistical Report. Nashville, TN; Tennessee Council of Juvenile and Family Court Judges, (1992). Annual Statistical Report. Nashville, TN.
2. Ibid.
3. American Psychological Association, (1993). Violence and Youth: Psychology's Response. Volume I: Summary Report of the American Psychological Association's Commission on Violence and Youth. Washington, DC, p. 19.
4. Ibid.
5. Ibid., p. 23.
6. Ibid., p. 24.
7. Tennessee Council of Juvenile and Family Court Judges, (1992). Annual Statistical Report. Nashville, TN.
8. Tennessee Commission on Children and Youth, (1992). Kids Count: The State of the Child in Tennessee. Nashville, TN.
9. American Psychological Association's 1993 report on Violence and Youth, p. 23.
10. Ibid., p. 25.
11. Population Reference Bureau, (1992, September). The Challenge of Change: What the 1990 Census Tells Us About Children. Washington, DC: Center for the Study of Social Policy, p. 51.
12. The Annie E. Casey Foundation, (1994). Kids Count Data Book: State Profiles of Child Well-Being. Baltimore, MD, p. 117.
13. Ibid., p. 81.
14. Tennessee Department of Health, (1993, October 12). Youth Risk Behavior Survey. Nashville, TN.
15. American Psychogical Association's 1993 report on Violence and Youth, p. 28.
16. Ibid.
17. Ibid.
18. Ibid., p. 22.

Prenatal Care

1. Nonuse of prenatal care: implications for social work involvement, (1994, May). Health and Social Work, 19(2), p. 84.
2. Ibid., p. 87.
3. Ibid., p. 84.
4. Ibid., p. 87.
5. Ibd., p. 86.
6. Ibid., p. 90.
7. Ibid.
8. Ibid., p. 91.
9. Ibid.
10. Ibid., p. 87.
11. Ibid.
12. Ibid., p. 91.
13. Ibid.
14. Ibid.
15. Ibid.

Low Birth Weight

1. The racial disparity in infant mortality, (1992, October 1). The New England Journal of Medicine, p. 1,022.
2. American Nurses' Association, (1987). Access to Prenatal Care: Key to Preventing Low Birthweight. Kansas City, MO, p. v.
3. The racial disparity in infant mortality, (1992, October 1). The New England Journal of Medicine., p. 1,023.
4. Ibid.

5. Ibid.

Infant Mortality
1. The Annie E. Casey Foundation, (1994). Kids Count Data Book: State Profiles of Child Well-Being. Baltimore, MD.
2. Schoendorf, K.C. et al., (1992, June 4). Mortality among black as compared with white college-educated parents. The New England Journal of Medicine. 326(23), p. 1,525.

Immunizations
1. Peter, G. , (1992, December 17). Childhood immunizations. The New England Journal of Medicine, p. 1,794.
2. Plotkin, S.I. and Plotkin, S.A. (1988). A short history of immunization. Vaccines. Philadelphia, PA: W.B. Saunders, p. 1-7.
3. Ibid., p. 587-611.
4. Nashville Immunization Coalition brochure, 1994.
5. The Tennessean, (1994, July 16). World News Extra, p. 7.
6. Ibid.
7. Ibid.
8. Peter, J., (1992, December 17). Childhood immunizations, The New England Journal of Medicine, p. 1,792.
9. Ibid.
10. Centers for Disease Control Advisory Memorandum #88 from the Tennessee Department of Health on April 4, 1994.
11. Ibid.
12. Ibid.
13. Peter, J. (1992, December 17). Childhood immunizations, The New England Journal of Medicine, p. 1,795.
14. Ibid., p. 1,794.

Child Deaths
1. Tennessee Department of Safety, (1993). Tennessee Motor Vehicle Traffic Accident Facts: 1988-1992. Nashville, TN.
2. Ibid., p. 27.

Teen Pregnancy
1. Dryfoos, J.G., (1990). Adolescents At Risk: Prevalence and Prevention. New York, NY: Oxford University Press, p. 65.
2. Ibid.
3. Ibid.
4. U.S. General Accounting Office, Health and Human Services Division, January, 1994.
5. Facts at a Glance, (1994, January). Washington, DC: Child Trends, Inc.
6. Dryfoos, J.G., (1990). Adolescents at Risk: Prevalence and Prevention. New York, NY: Oxford University Press, p. 70.
7. The Annie E. Casey Foundation, (1994). Kids Count Data Book: State Profiles of Well-Being. Baltimore, MD.
8. National Center for Education Statistics, (1993, October). Youth Indicators 1993: Trends in the Well-Being of American Youth. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement.
9. Dryfoos, J.G., (1990). Adolescents at Risk: Prevalence and Prevention.
10. Ibid., p. 74
11. Ibid., p. 75.
12. Facts at a Glance, (1994, January). Washington, DC: Child Trends, Inc.
13. Ibid.
14. Ibid.
15. Ibid.
16. National Commission on Children, (1991). Beyond Rhetoric: A New American Agenda for Children and Families. Washington, DC, p. 226-227.

HIV/AIDS
1. U.S. Department of Health and Human Services, Centers for Disease Control, HIV/AIDS Surveillance Bulletin, April 1991, pp. 1-18; S.B. Manoff et al., Acquired Immunodeficiency Syndrome in Adolescents: Epidemiology, Prevention and Public Health Issues," Centers for Disease Control: Current Issues in Pediatrics 8 (1989):309-314; U.S. Department of Health and Human Services, National Center for Health Statistics, Health, United States, 1989 (Washington, D.C.: U.S. Department of Health and Human Services, Public Health Services, 1990) p. 20; Children's Defense Fund, S.O.S. America! A Children's Defense Fund Budget (Washington, D.C.: Children's Defense Fund, 1990), p. 58.
2. Tennessee Department of Health, (1993). HIV/AIDS Among Children and Adolescents in Tennessee: Update Through October 31, 1993.
3. Ibid.
4. Ibid.
5. Newborns with AIDS, (1994, March 7). Newsweek, p. 53.
6. Tennessee Department of Health, (1993). HIV/AIDS Among Children and Adolescents in Tennessee: Update Through October 31, 93.
7. Tennessee Department of Health , (1993, October 12). Youth Risk Behavior Survey. Nashville, TN.

Sexually Transmitted Diseases

1. Millstein, S., (1988). The Potential of School Linked Centers to Promote Adolescent Health and Development. New York, NY: Carnegie Council on Adolescent Development, p. 6.
2. Centers for Disease Control, 1990 Division of STD/HIV Prevention Annual Report, "Syphilis" and Gonorrhea" tables.
3. Centers for Disease Control, 1991; American Social Health Association, 1991.
4. Dryfoos, J.G., (1990). Adolescents At Risk: Prevalence and Prevention. New York: Oxford University Press.
5. Ibid.
6. Ibid., p. 66
7. Ibid.
8. Rosenbaum, E. And Kandel, (August, 1990). Early onset of adolescent sexual behavior and drug involvement. Journal of Marriage and the Family. 52. pp. 783-789.
9. Ibid.

Teen Violent Deaths

1. Tennessee Department of Health, (1993). Picture of the Present. Part Tw0. Nashville, TN.
2. Ibid.
3. Ibid.
4. Ibid.

Enrollment, etc.

Data in the introductory section were gathered from the Tennessee State Department of Education's Annual Statistical Reports from 1989-90, 1990-91, 1991-92, and 1992-93.

Student Learning

Data in this section were gathered from State Testing and Evaluation Center's 1992-93 Tennessee Student Test Results: TCAP.

ACT Scores

Data in this section were gathered from The American College Testing program's Student Profile of Tennessee students who took the test in 1993 and score reports from the test administration of 1993.

Dropping Out

1. National Commission on Children, (1991). Beyond Rhetoric: A New American Agenda for Children and Families. Washington, DC, p. 235.
2. U.S. Department of Commerce, Bureau of the Census, 1990 Census of Population and Housing, Public Use Microdata, File: Tennessee.
3. U.S. General Accounting Office, (1994, January). Residential Care: Some High Risk Youth Benefit, But More Study Needed. A Report to the Chairman, Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate. Wahington, DC.
4. T.C.A. 49-6-3001
5. T.C.A. 49-6-3017
6. National Commision on Children, (1991). Beyond Rhetoric: A New American Agenda for Children and Families. Washington, DC.

Special Education

1. Tennessee Department of Education, (1993). Special Education Manual. Developed by the Special Education Division of the Department of Education, Nashville, TN, p. 14.1.
2. Ibid., p. 17.4.
3. Ibid.
4. Ibid., p. 1.1.

School Violence

1. Office of Educational Research and Improvement, (1993). Reaching the Goals: Goal 6 - Safe, Disciplined, and Drug-Free Schools. Washington, DC: U.S. Department of Education, p. 8.
2. American Psychological Association, (1993). Violence and Youth: Psychology's Response. Volume I: Summary Report of the American Psychological Association Commission on Violence and Youth. Washington, DC.
3. Ibid., p. 20.
4. Ibid., p. 8.
5. Ibid., p. 17.
6. Ibid., p. 18-19.

Glossary

Average ACT Composite Scores is the average of the four subtests of the American College Testing (ACT) college entrance examination. The subtests are: reading; mathematics; English; and scientific reasoning.

Births Lacking Adequate Prenatal Care is the percent of births which have inadequate or intermediate prenatal care measured by the Kessner Index. Kessner Index is a scale of adequacy of prenatal care based on standards of the American College of Obstetricians and Gynecologists. This index of adequacy of prenatal care is based on the number of prenatal visits adjusted for gestational age.

Child Abuse and Neglect Rate is the number of cases per 1,000 children under 18 years old in which someone causes foreseeable and avoidable injury or impairment to a child or contributes to the unreasonable prolonging or worsening of an existing injury or impairment in a child.

Child Death Rate is the number of deaths per 100,000 children aged 1-14 from all causes. The data are reported by residence. (This rate may appear excessively high in counties with small populations although few child deaths occurred.)

Children Receiving AFDC is the percent of children under 18 years old who received financial support from Aid to Families with Dependent Children (AFDC) which provides subsistence-level income for children and families.

Children Referred to Juvenile Courts is the percent of children under 18 years old who are referred to a juvenile court. There are three categories of reasons for referrals. The first category includes offenses against persons, offenses against property, illegal conduct, violation proceedings, and status offenses. The second category involves issues affecting the safety and well-being of the referred child such as abuse, dependency, neglect, termination of parental rights, etc. The third category includes judicial actions taken on behalf of the child or upon request of the child and parent or guardian.

Commitments to State Custody are court orders issued by a juvenile court judge or referee giving legal custody of a child to the state. Children may be committed by a juvenile court to the custody of the Department of Education (Tennessee Preparatory School), the Department of Human Services, the Department of Mental Health and Mental Retardation, the Department of Youth Development, or committed on a Juvenile Court Commitment Order (JCCO).

Children Remaining in State Custody are children under 21 years old who are in the legal custody of the state on June 30, the last day of the state fiscal year.

High School (Grade 9-12) Dropouts is the number of dropouts per 100 students of grades 9-12 in a calendar year from June to June (the school year and preceding summer) divided by net enrollment at the end of school year. The number of dropouts is collected and reported by school systems utilizing the Tennessee School Register (TSR).

Infant Mortality Rate is the number of deaths of per 1,000 live births of infants under one year of age. The data are reported by residence.

Low-Birth-Weight Babies is the percent of live births recorded as low-birth-weight babies who weigh under 2,500 grams (5.5 pounds) at birth.

Per Capita Income by County is the per capita personal income for a county.

Sexually Transmitted Disease Rate is the number of teens ages 15-17 per 100,000 who were diagnosed with sexually transmitted diseases.

Students in Special Education is the percent of students in Tennessee school systems who received special education services. This group includes gifted children and those with disabling conditions including learning disabilities, mentally retarded, speech or language impaired, emotionally disturbed, autistic, health impaired, physically impaired, deaf, hearing impaired, visually impaired, deaf/blind, multihandicapped, functionally retarded, developmentally delayed, or traumatic brain injury.

Teen Pregnancy Rate is the number of live births, reported fetal deaths, and induced terminations of pregnancy per 1,000 women aged 15-17.

Teen Violent Death Rate is the number of deaths per 100,000 of teens ages 15-19 from homicide, suicide, and accidents.

Youth Unemployment Rate is the percent of unemployed persons ages 16-19 years old, expressed as a percent of the labor force for ages 16-19.

Tennessee Health Department Regions for the chart on page 43

East 1	Central 4	
Carter	Cannon	Lewis
Greene	Clay	Lincoln
Hancock	Cumberland	Marshall
Hawkins	DeKalb	Maury
Johnson	Fentress	Moore
Unicoi	Jackson	Perry
Washington	Macon	Wayne
	Overton	
East 2	Pickett	West 7
Anderson	Putnam	Benton
Blount	Smith	Carroll
Campbell	Van Buren	Crockett
Claborne	Warren	Dyer
Cocke	White	Gibson
Grainger		Henry
Hamblen	Middle 5	Lake
Jefferson	Cheatham	Obion
Loudon	Dickson	Weakley
Monroe	Houston	
Roane	Humphreys	West 8
Scott	Montgomery	Chester
Sevier	Robertson	Decatur
Union	Rutherford	Fayette
	Stewart	Hardeman
Central 3	Sumner	Hardin
Bledsoe	Trousdale	Haywood
Bradley	Williamson	Henderson
Franklin	Wilson	Lauderdale
Grundy		McNairy
McMinn	Central 6	Tipton
Marion	Bedford	
Meigs	Coffee	
Polk	Giles	
Rhea	Hickman	
Sequatchie	Lawrence	

Appendix: Tennessee Regions

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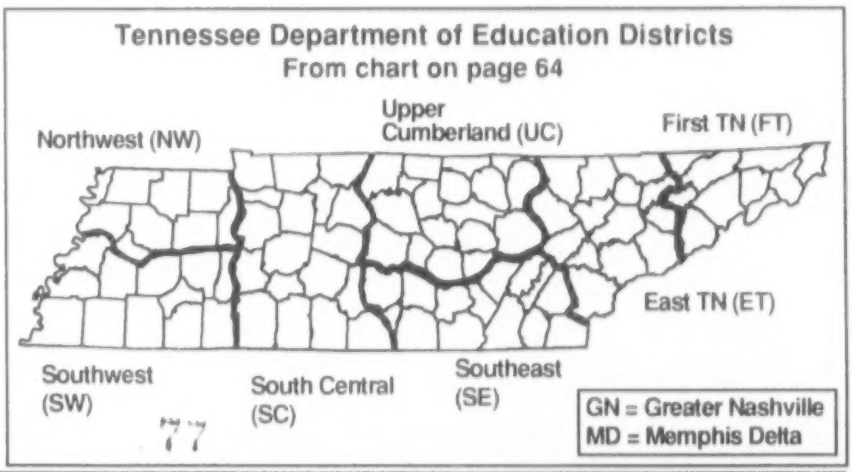

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Tennessee KIDS COUNT

Tennessee KIDS COUNT Director - Denise Dunbar, Ed.D
Tennessee KIDS COUNT Research Analyst - Jing Zhou
Editor - John T. Harding
Executive Editor - Linda O'Neal
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TCCY Coordinators of Regional Councils on Children and Youth

Debbie Anderson
Northwest Council on Children and Youth
P.O. Box 505
112 West Maple
Dresden, TN 38225
(901) 364-5000
FAX: (901) 364-5000

Marilyn Davis
Southeast Council on Children and Youth
540 McCallie Avenue, Suite 643
Chattanooga, TN 37402
(615) 634-6210

Kathy Daniels
Upper Cumberland Council on Children and Youth
1225 South Willow Avenue
Cookeville, TN 38501
(615) 432-4111
FAX: (615) 432-6010

Kay Hester
Mid-Cumberland Council on Children and Youth
Gateway Plaza, First Floor
710 James Robertson Parkway
Nashville, TN 37243-0800
(615) 532-1579
FAX: (615) 741-5956

Robert Smith
East Tennessee Council on Children and Youth
531 Henley Street #710
Knoxville, TN 37902
(615) 594-6658
FAX: (615) 594-6658

Judy Matthews
Southwest Council on Children and Youth
State Office Building Box 13
Jackson, TN 38301
(901) 423-6545
FAX: (901) 423-6545

Juanita White
Memphis/Shelby County Children and Youth Council
170 North Main, Room 707
Memphis, TN 38103
(901) 543-7657
FAX: (901) 543-7657

Diane Wise
Northeast Tennessee Council on Children and Youth
207 North Boone Street, Suite 800
Johnson City, TN 37604
(615) 928-0224
FAX: (615) 928-5209

Elaine Williams
South Central Tennessee Council on Children and Youth
P.O. Box 955
Spring Hill, TN 37174-0955
(615) 388-1053 or 381-2040
FAX (615) 381-2053

Tennessee Commission on Children and Youth

Philip Acord, Chair
Chattanooga

Cleo Brooks Boyd
Jackson

Kristin Cunningham
Nashville

Eric Dupree
McKenzie

Cheryl Gannon
Cleveland

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Memphis

Gerald Stow
Brentwood

Chiffonda Washington
Nashville

Donna Roberts Wohlford
Bristol

Linda O'Neal, Executive Director
Janet Coscarelli, Assistant Director

Tennessee KIDS COUNT Technical Advisory Committee

May W. Shayne, Chairperson
Director, Center for State and Local Government Policy, Vanderbilt Institute for Public Policy Studies

Louise Barnes
Regional Coordinator, Children and Adolescents Section
Tennessee Department of Mental Health and Mental Retardation

Benjamin Brown
Director of Accountability Systems
Tennessee Department of Education

David Cordray
Professor of Public Policy
Vanderbilt Institute for Public Policy Studies

Charles Glisson
Professor, College of Social Work
University of Tennessee

Lorraine Greene
Deputy Director, "I Have a Future"
Meharry Medical College

Robert Innes
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Vanderbilt University

William Robert Ives
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Tennessee Hospital Association

Robert Kronick
Professor of Education, College of Education
University of Tennessee

Irving Lazar
Research Professor of Public Policy
Vanderbilt Institute for Public Policy Studies

Lise McInturff
Executive Director
Tennessee Voices for Children

Gregory Meynard
Director of Planning
Tennessee Department of Youth Development

Matt Murrey
Professor, Center for Business and Economic Research
University of Tennessee

George Plumlee
Chief of Technical and Informational Services
Tennessee Department of Health

Ron Simmons
Research Specialist
Tennessee Board of Regents

Joanne Jankovic Thompson
Assistant Professor, College of Social Work
University of Tennessee

Charles Wilson
Director of Child Welfare Services
Tennessee Department of Human Services

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